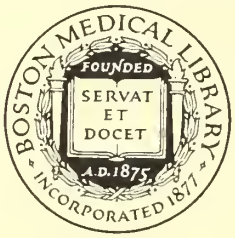
COUNTWAY LIBRARY
HC 3JBT 5

BOSTON
MEDICAL LIBRARY



IN THE
Francis A. Countway
Library of Medicine
BOSTON

Digitized by the Internet Archive
in 2016

https://archive.org/details/journalofmedical3919alab

JOURNAL

of the Medical Association of the State of ALABAMA



THE FRANCIS A. COUNTWAY LIBRARY OF MEDICINE
BOSTON
31 JUL 1969

IN THIS ISSUE

The Concept of "Readiness" and Learning Disabilities . . . 29

The Meal Ticket Syndrome 37

Normal and Abnormal Behavior From Learning 40

Write it any way you please

Cordran®

Flurandrenolone



Cream Cordran contains flurandrenolone, 0.05 percent, stearic acid, cetyl alcohol, mineral oil, polyoxyl 40 stearate, ethylparaben, glycerin, and purified water.

Lilly

Additional information available upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

900415

JULY 1969



Dear Doctor, You made me what I am today - a whole lot slimmer!

TEPANIL—the right start in support of the weight-control program *you* recommend. It reduces the appetite. Doesn't kill it. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation. Because TEPANIL works on the appetite, not on the "nerves."

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable potients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potentiol benefits outweigh potentiol risks.

Adverse Reactions: Rarely severe enough to require discontinuotion of therapy, unpleasont symptams with diethylpropion hydrochloride have been reported to occur in relatively law incidence.

As is characteristic of sympathomimetic agents, it may accasionally cause CNS effects such as insomnia, nervausness, dizziness, anxiety, and jitteriness. In contrast, CNS depressian has been reported. In o few epileptics an increase in canvulsive episodes has been reported.

Sympathomimetic cardiovascular effects reparted include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blaod pressure. One published report describes T-wave changes in the ECG af o healthy yaung mole after ingestion of diethylpropian hydrochloride; this was on isalated experience, which has nat been reparted by athers.

Allergic phenamena reported include such canditians as rash, urticoria, ecchymosis, and erythema. *Gostrointestinol effects* such as diarrhea, canstipation, nausea, vomiting, ond abdominal discomfort have been reported.

Specific reports on the hematopoietic system include two each of bone morraw depression, agranulocytosis, ond leukopenia.

A voriety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair lass, muscle pain, decreosed libido, dysuria, ond palyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 o.m.); TEPANIL: One 25 mg. tablet three times daily, one haur before meals. If desired, an additianal toblet may be given in midevening to avercome night hunger. Use in children under 12 years of age is not recammended.

Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride)

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144 T-918A U.S. PATENT NO. 3,001,910 5/6

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON

31 JUL 1969

LACTINEX®

TABLETS & GRANULES

- **to help restore and stabilize the intestinal flora**
- **for fever blisters and canker sores of herpetic origin**

Lactinex contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.[1,2,3,4,5,6,7,8]

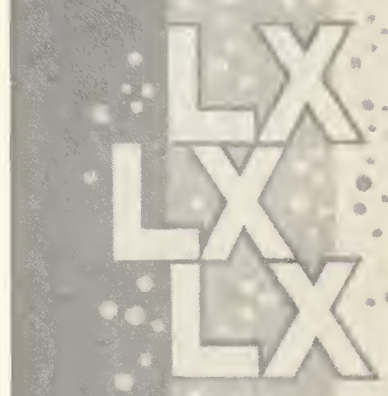
No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.

Baltimore, Maryland 21201

(LX-05)



References:
(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

THE JOURNAL

of the

Medical Association of the State of Alabama

Volume 39 • July, 1969 • No. 1

Office of Publication
19 So. Jackson St. Montgomery, Ala. 36104
Subscription Price $5.00 Per Year
$1.00 Per Copy

Second Class Postage Paid at Montgomery, Alabama. Published monthly in Montgomery at 19 South Jackson Street.

Editor-in-Chief
William L. Smith, M. D. Montgomery

Managing Editor
L. P. Patterson Montgomery

Assistant Managing Editor
Mary Nell Williford Montgomery

Associate Editors
J. P. Collier, M. D. Tuscaloosa
John M. Chenault, M. D. Decatur
M. Vaun Adams, M. D. Mobile

Officers of the Association

President
C. Kermit Pitt, M. D. Decatur

President-Elect
S. Buford Word, M. D. Birmingham

Vice-Presidents
F. M. Phillippi, Jr., M. D. Brewton
J. E. Cameron, M. D. Alexander City
O. Emfinger, M. D. Union Springs
Wood S. Herren, M. D. Birmingham

Secretary-Treasurer
William L. Smith, M. D. Montgomery

Executive Director
L. P. Patterson Montgomery

The State Board of Censors
John M. Chenault, M. D., Chmn. Decatur
J. P. Collier, M. D. Tuscaloosa
Hugh E. Gray, M. D. Anniston
Paul W. Burleson, M. D. Birmingham
L. L. Hill, M. D. Montgomery
M. Vaun Adams, M. D. Mobile
J. D. Bush, M. D. Gadsden
E. L. Strandell, M. D. Brewton
John W. Davis, Jr., M. D. Montgomery
J. Garber Galbraith, M. D. Birmingham

State Health Officer
Ira L. Myers, M. D. Montgomery

Delegates and Alternates to the American Medical Association

(Terms expiring December 31 of year shown.)

1970
Delegate—E. Bryce Robinson, Jr., M. D., Fairfield
Alternate—W. E. White Anniston

1971
Delegate—M. Vaun Adams, M. D. Mobile
Alternate—E. L. McCafferty, Jr., M. D. Mobile
Delegate—P. W. Burleson, M. D. Birmingham
Alternate—Robert Parker, M. D. Montgomery

CONTENTS

President's Page 4

The Woman's Auxiliary 6

Physician Placement Service 9

Editorial Comment 14

- There Is A Hidden Threat To Public Health In Chiropractic Bills 14
- The 'Scarecrow of Oz' Was Born Two Generations Too Soon 15
- Competitive Spirit Injected Into Safe-Driver Contest 16
- Guest Editorials 17
  - Chiropractic Condemned In Stinging JAMA Editorial 17
  - Therapeutic Orphans 19

Behavior Modification Institute 23

Scientific Section 29

- The Concept of "Readiness" and Learning Disabilities, Charles L. Shedd, Ph. D., Birmingham 29
- The Meal Ticket Syndrome, Henry Spira, M. D., F. A. P. A., Birmingham 37
- Normal and Abnormal Behavior From Learning, Wallace Marshall, M. D., Montgomery 40

Alabama Department of Public Health Manpower Shortage No. 1 Health-Planning Challenge, Joyce T. Murphree 51

Case Histories in 1968 Malaria Outbreak In Chambers 57

The Month in Washington 66

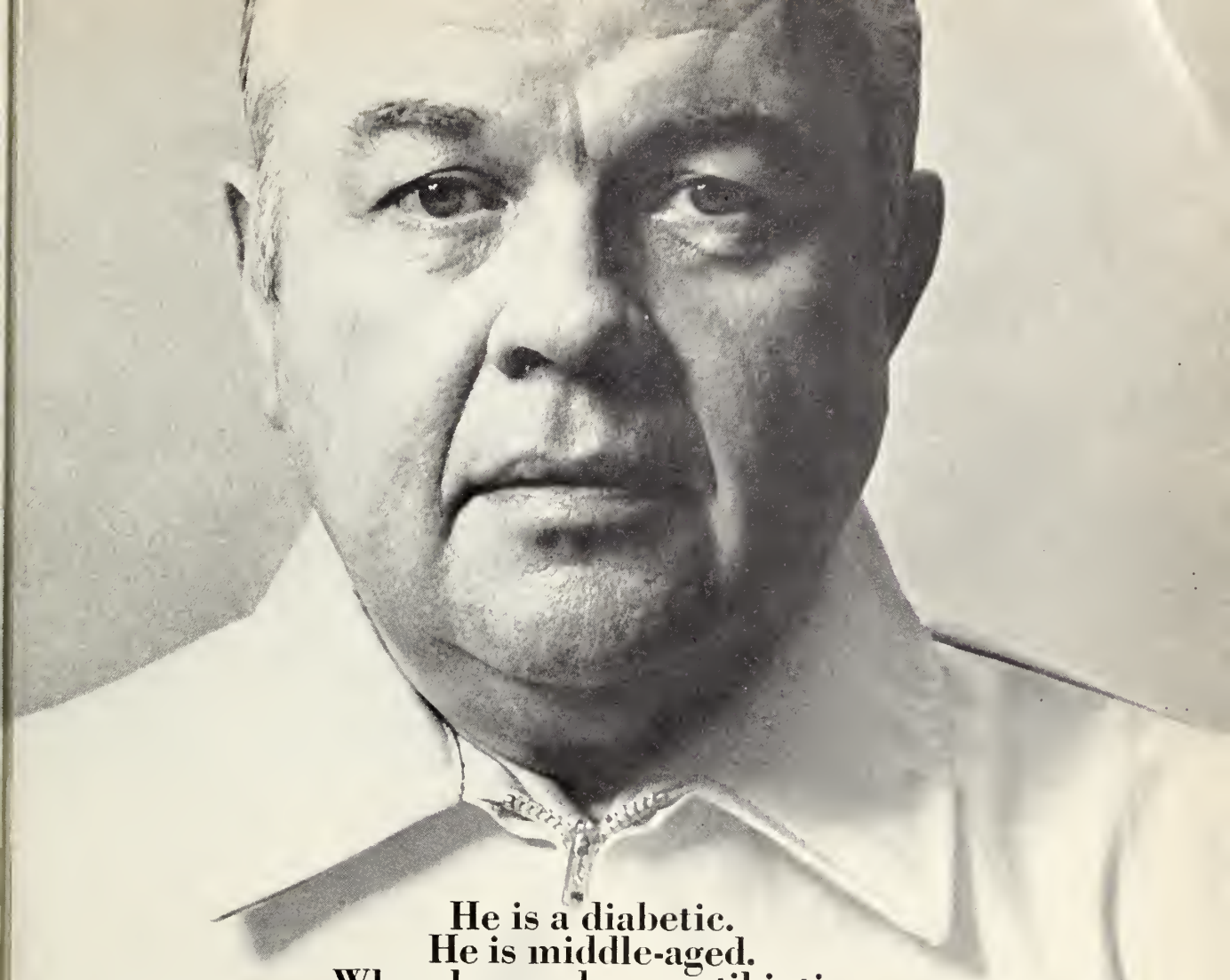
300 Psychiatrists Busy With Moscow's Mental Health 70

The Book He Planned on "Serenity" May Never Be Written 73

Around the State 76

- Vital Statistics 76
- Alabamian To Preside Over 46th Annual Auxiliary Convention 85
- An Interesting Name For An ALAPAC Director 86
- New Physicians Licensed to Practice In Alabama 88
- Days of VD In Alabama Are Numbered, Dr. "Why" Smith Declares 100
- Fractured Elbows As Seen By An Alabama Orthopodist 103

Books of Professional Interest 107



He is a diabetic.
He is middle-aged.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

l guard susceptible patients against intestinal monilial over-
›wth during broad-spectrum therapy—the protection of
›statin is combined with demethylchlortetracycline in
ECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN
he broad-spectrum therapy that prevents monilial
ergrowth.

ectiveness: Because its antibacterial component is DECLOMYCIN
methylchlortetracycline, DECLOSTATIN should be equally or more
ctive therapeutically than other tetracyclines in infections caused by
acycline-sensitive organisms. The antifungal component, Nystatin,
tects against superinfection by antibiotic-resistant fungal overgrowth
rticularly monilia) in the intestinal tract.

ntraindication: History of hypersensitivity to demethylchlortetracy-
ne or nystatin.

rning: In renal impairment, usual doses may lead to excessive accum-
tion and liver toxicity. Under such conditions, lower than usual doses
: indicated, and, if therapy is prolonged, serum level determinations
y be advisable. A photodynamic reaction to natural or artificial sun-
ht has been observed. Small amounts of drug and short exposure may
›duce an exaggerated sunburn reaction which may range from ery-
ma to severe skin manifestations. In a smaller proportion, photo-
ergic reactions have been reported. Patients should avoid direct
›osure to sunlight and discontinue drug at the first evidence of skin
comfort. Necessary subsequent courses of treatment with tetracy-
nes should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

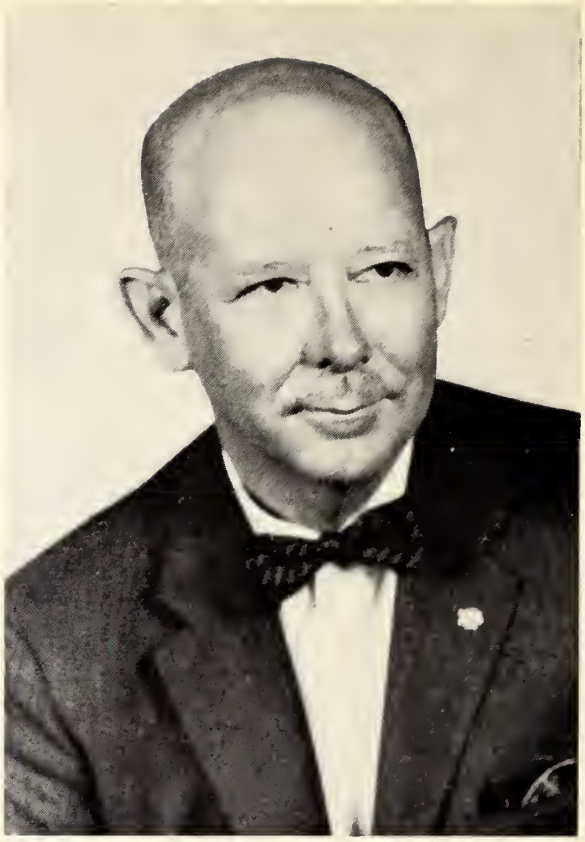
Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

346-4

President's Page



C. Kermit Pitt

A POLITICAL CREED

"I am a free citizen in a free nation.

Whoever diminishes my freedom as an individual diminishes the sum total of freedom in my country.

I am also a physician, free thus far to treat my patients to the best of my ability.

Abridge that freedom and the health of my patients is adversely affected.

These things being true, I cannot—I will not— stand idly by when these hard-won freedoms are under attack.

For I believe that the values upon which this country was founded are immutable and have not been eroded by the passage of years.

I believe that I, as a free citizen in a free land, am obligated to defend my beliefs in the ways permitted to me, and required of me, by our form of government.

Therefore, let no man seek to bar me from the political process; for it would be akin to denying my right to participate in the process that determines free government."

Dedication and devotion of physicians to their profession offer no excuse for abdication of citizenship. Rather the advantages of education, continued contact with great numbers of people and the respect with which we are held by our fellow men increase our obligations and responsibilities in public affairs ("the intelligent exercise of public responsibility"). Too often we have wanted to excuse ourselves by reason of being busy. The medical profession is a demanding one but people in other occupations and professions who are striving to achieve excellence of performance and increase their education and effectiveness also have the problem of time. Physicians have also often tended to deny their interest in politics as activity somewhat unbecoming to men of respectability. Again if we define politics as involvement in public affairs none of us can deny participation.

It has been said that politics will determine the future of our nation and certainly of our profession. We must not remain aloof from the problems of our day be they professional or secular, but in the health field alone there is ample challenge for our interest. The 89th Congress of the United States passed more health legislation than all the other Congresses combined and the present

Congress has already introduced more than 650 bills related to health. Can we afford to fail to be influential in government affairs? Can any physician consider himself above politics or indifferent to government?

Mr. Robert Finch, Secretary of Health, Education and Welfare, recently stated his conviction that the American people will not much longer tolerate the inequity between the state of the healing arts and the delivery system. An executive of the United States Chamber of Commerce recently made the same suggestion.

Powerful, organized and unified forces are at work for change in our nation. Whether changes, which are certain to occur, will bless us as individuals and as a nation will depend upon the wisdom and objectives of those willing to get and keep themselves involved. Our profession has potential for great political power but to be really effective we must act not alone as individuals but as an organized unit. Without wishing to make an unsavory comparison, I cite the power of today's labor unions as an illustration of what unification of political power can accomplish.

The political arm of the medical profession in the State of Alabama is ALAPAC and that of the nation AMPAC. These organizations have existed for only a few years—AMPAC for some nine years and ALAPAC for less—and like all initial undertakings have been attended by some errors, nevertheless, they have accomplished much and are rapidly becoming powerful influences. Maximum accomplishment will not be attained as long as membership recruitment is the principal goal. It behooves us all to become active in these organizations so that we may add our influence to that of those who seek better health for a better world.



C. Kermit Pitt, M. D.

You can give a better ear exam EASIER with the new Hotchkiss™ Otoscope

A radical advance in otoscope design, the Hotchkiss employs the principles of modern optics to give you a brighter, clearer, more informative view of the ear canal and tympanic membrane. It weighs just five ounces (including batteries) and fits into your shirt or jacket pocket. You can carry it anywhere; use it repeatedly without fatigue. And the Hotchkiss is built to stand up to far rougher treatment than you're likely to give it.

See for yourself. Clip and mail the coupon, and our Representative will call for an appointment to show you the new Hotchkiss Otoscope in your office.

SK&F **Smith Kline & French Laboratories**

Smith Kline & French Laboratories E-30 A
1500 Spring Garden Street
Philadelphia, Pa. 19101

I would like your Representative to call for an appointment to show me the Hotchkiss Otoscope.

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

☐ Send descriptive literature

The Woman's Auxiliary

President, Mrs. Ben H. Johnson, Jr.
President-Elect, Mrs. Howard C. Johnson
Northeast District Vice President, Mrs. James D. Holliman, Jr.
Northwest District Vice President, Mrs. Gene Qualls
Southeast District Vice President, Mrs. George Andrews
Southwest District Vice President, Mrs. Andrew D. Henderson
WAMASA Editor, Mrs. William L. Smith

AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals."

We are well into the Auxiliary year and there is much work to be done just to get the housekeeping in order. I have been busy with lists to be sent to National, distributing the Guide Books to every county president, and the Year Book material must be readied. Right now I am sending out the credential cards to the delegates to the National Convention. Doctors, this is the fun time for our Auxiliary members, and I hope your wives take you along to this exciting meeting. Great plans have been made for this big event, I don't know if New York is ready for us, but we are ready for New York.



Mrs. Ben H. Johnson

One of the nicer meetings to come my way was in Birmingham at the Vestavia Country Club when the Shelby County Auxiliary hosted their friends to a luncheon meeting. What a great way to emphasize public relations! This is a small auxiliary with only four active members, but what a terrific group of girls. They raise money for AMA-ERF, work in the nursing home in Alabaster, and demonstrate their gracious hospitality with this one big meeting annually when they tell the lovely women of their community all about the Medical Auxiliary.

And I am still excited about the really terrific AMPAC Workshop in Washington. This was my first trip to Washington since we honeymooned there many happy years ago, and I was thrilled to be in our great CAPITOL CITY once more. We were housed at the beautiful Sheraton Park Hotel and it is so large we were given maps to find our way to the meeting rooms. Wings of that hotel stretched in every direction and one had to allow plenty of time to get from one event to another and it was not safe to follow the crowd, lest one attend the wrong meeting. Somehow, our own Senators seem more impressive in Washington than when they are politicking at home and it was nice to see them there. It was all great, we listened to politicians and to the smart young men who help them to get elected. I was so inspired that I am going to really beat the drums for membership into both ALAPAC and AMPAC. Be sure to include dues for your wife when you send in your dues. This is really where our dollars can work for

(Continued on Page 8)

Design for an ear anti-infective

Designed to act promptly against bacterial pathogens and pain

Otitis media (when the tympanic membrane is perforated) and otitis externa both respond to the bactericidal action of Furacin® (nitrofurazane) in Furacin-HC (nitrofurazone-hydrocortisone) Otic. Its broad antibacterial spectrum includes most of the organisms encountered in surface infections (but only certain strains of Pseudomonas). The hydrocortisone component in Furacin-HC Otic affords rapid relief of painful swelling.

Designed to let the ear drain freely

The water-soluble base of Furacin-HC Otic permits free drainage and provides a hygroscopic vehicle.

Designed to please and protect the patient

Topical Furacin-HC Otic lets you reserve systemic preparations for systemic infections. It rarely irritates inflamed epithelial surfaces, and cross resistance or cross sensitization with antibiotics does not occur. In addition, nonmacerating, odorless Furacin-HC Otic softens wax to facilitate removal af cerumen.

Also available: Furacin® Otic (nitrofurazone with nifuroxime and diperodon HCl). The wide antibacterial range of Furacin is augmented by the antimycotic activity of Micofur® (nifuroxime). Diperodon hydrachloride, on efficient local anesthetic, promptly subdues pain and itching. Indicated in bacterial atitis externa, otamycosis or bacterial otitis media (when the eardrum is perforated).

Precautions: Sensitizatian to nitrofurazane may occur with prolonged use and is more likely ta develop in eczematous otitis externa. To minimize such reactions (a) limit application to a week or less, and (b) avoid use of excessive amounts which may run down the face.

This preparation is not indicated for use in treatment of cholesteatoma, where surgical interventian is necessary.

Contraindications: The usual contraindications for preparations containing hydrocortisone should be observed, such as tuberculous lesians of skin ar ear, acute herpes simplex, vaccinia and varicella, superficial fungus and yeast infections.

Formula: Furacin®-HC Otic contains 0.2% Furacin, brand of nitrofurazone, and 1.0% hydrocortisane acetate in a water-soluble hygroscopic base of glycerin and polyethylene glycol.

Furacin® Otic contains 0.2% Furacin, brand of nitrofurazone, 0.375% Micofur®, brand of nifuroxime, and 2% diperodon hydrochloride dissolved in water-soluble, nondrying, hygroscopic polyethylene glycol.

™Originators and Developers of The Nitrofurans
EATON LABORATORIES
Division of The Norwich Pharmocal Company
NORWICH, NEW YORK 13815

Furacin®-HC Otic
nitrofurazone/hydrocortisone

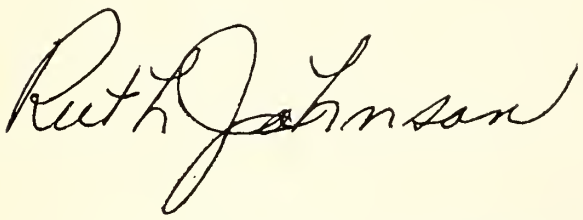
Furacin® Otic
nitrofurazone with nifuroxime and diperodon HCl



(Continued from Page 6)

us in Washington and in our own State Legislature.

Before this is in print, plans will have been made for the State Convention in Mobile in 1970. These events just don't happen, plans have to be made and there is no putting off the work in this job no matter what crisis may arise at home or away with those at school. It is an exciting life, but I must say I am enjoying the summer vacation from school car pools, cheer leader try-outs, and exams. But, then, isn't everyone?



(Mrs. Ben H. Johnson, Jr.)

President, WAMASA

ORTHOPEDIST; UROLOGIST

285 Bed GM&S Hospital

Salary up to approximately $25,000 depending on qualifications; liberal fringe benefits; moving expenses paid; equal opportunity employer.

Contact

F. S. SPRINGALL, M. D.

Chief, Surgical Service

VA Hospital

215 Perry Hill Road

Montgomery, Alabama 36109

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: MRS. ELIZABETH HARKINS, ACSW, *Coordinator of Admissions* or

CHARLES W. NEVILLE, JR., M. D., *Assistant Professor of Psychiatry and Medical Director*

Area Code 704 - 254-3201

PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. MASA members having knowledge of practice opportunities or wishing to relocate their own practices are urged to communicate with the Placement Service. For further information: write Mr. Emmett Wyatt, Executive Assistant, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama 36104, or Telephone 263-6441.

Locations Wanted

General Practice—

Age 44, Medical College of Alabama, 1967, seeking associate practice in town of 12,000 plus population in central or south Alabama. LW-1

Age 56, Georgetown University 1938; seeking solo, group or associate practice, with general surgery. LW-2

Age 52; University of Chicago 1950; seeking group, industrial, institutional or student health position. LW-3

Age 31, Western Reserve, 1964; seeking group, associate or institutional practice. LW-4

Age 38; University of Oklahoma, 1955; seeking associate, institutional or industrial practice; in town of 10,000 plus population; interest in surgery. LW-5

Age 28; University of Tennessee, 1965. LW-7

Age 27, Medical College of South Carolina, 1966; seeking location in Gadsden area or in southern part of state in town of 5-7,000 population; available July 1, 1971. LW-7/1

Age 38; Medical College of Alabama, 1957; seeking location in south Alabama. LW-7/2

Age 60, University of Arkansas 1932, seeking location for general or industrial practice. Available May 1969. LW-7/3

Age 42; Medical College of Alabama 1957; seeking location in central Alabama, near Montgomery. LW-7/4

Internal Medicine—

Age 36, Medical College of Alabama, 1963; seeking solo, group, or associate practice. LW-8

Age 34; Hahnemann Medical College 1959; Board eligible, National Board; seeking solo, group, or associate practice. Available immediately. LW-11

Age 35; University of Tennessee 1958; Board certified; seeking group, industrial or institutional practice. LW-12

Age 37, Duke University, 1956; Board certified, seeking group, associate, or institutional practice. LW-13

Age 33; University of Miami 1962; Board eligible; National Board; seeking solo, group practice, hospital practice, or industrial practice. Available July 1969. LW-13/1

Age 31; Medical College of Georgia 1963; seeking location for practice of internal medicine-cardiology. Available 1970. LW-13/2

Neurology—

Age 32, Medical College of Georgia, 1964, seeking assistant or associate, or institutional practice. LW-14

Age 31; Harvard 1962; Board eligible; National Board; seeking solo, group or associate practice. Available July 1969. LW-15

Age 30; Medical College of Alabama 1962; Board eligible; National Board; seeking solo, group, associate or institutional practice. Available January 1969. LW-16

Age 29, Indiana Univ., 1964; Board eligible; seeking assistant or associate practice in city of over 100,000 population; available July 1, 1969. LW-17/1

Obstetrics-Gynecology—

Age 35, Vanderbilt University, 1950. Board eligible. LW-18

Age 49, University of Nebraska, 1943; Board certified, seeking group or institutional practice. LW-19

Age 34, Medical College of Virginia, 1961, Board eligible, seeking group or associate practice. LW-20

Age 33; University of Illinois, 1964; seeking associate practice. LW-21

Ophthalmology—

Age 33; St. Louis University, 1962; seeking solo, or associate practice; available July 1, 1969. LW-21/1

Otolaryngology—

Age 32, University of Pennsylvania 1962, seeking associate practice. Available April 1970. LW-21/2

Age 35, University of Miami 1959, seeking location in city of 150,000 plus population. Available August 1970. LW-21/3

Psychiatry—

Age 52, Chicago Medical School 1939; Board eligible; seeking group or institutional practice, preferably near Gulf Coast. LW-22

Pediatrics

Age 30; Tulane University 1964; seeking associate practice in south Alabama in city of 20,000-80,000 population. Available September 1969. LW-23

Radiology

Age 28; Northwestern University 1964; completing radiology residency. Available July 1971. LW-24

Surgery—

Age 30; Duke University School of Medicine, 1964; seeking location in larger cities. LW-26

Age 33; University of Missouri, 1961; seeking group or associate practice. Available January 1969. LW-27

Locations Wanted

(Continued)

Age 38; Emory University, 1956; Board eligible, seeking group, associate, or institutional practice. LW-28

Age 37; Faculty of Medicine, Manitoba, 1957; Board certified; seeking associate or institutional practice. LW-29

Age 34; University of Santo Tomas, 1961; Board eligible, seeking group or associate practice. LW-30

Age 35; University of Santo Tomas, 1956; Board eligible, seeking solo, group or industrial or associate or institutional practice. LW-31

Age 36, Indiana University 1961; Board eligible; seeking practice in city of 100,000 plus population. Available July 1969. LW-31/1

Age 37, University of Paris 1961; seeking group or institutional practice in city of 80,000 plus population. Available July 1969. LW-31/2

Age 48; Marquette University 1943; Board eligible; seeking institutional practice in east Alabama. Available July 1969. LW-31/3

Age 48; University of Pennsylvania 1950; Board eligible; seeking solo or group practice. LW-31/4

Age 36, Emory University 1959, Board certified, seeking associate practice. Available September 1970. LW-31/5

Urology—

Age 30; Louisiana State University, 1963; Board eligible, seeking associate, or group practice. LW-32

Age 31, Chicago Medical School 1963, seeking associate practice in Montgomery. Available July 1970. LW-32/1

Student Health—

Age 40, University of Oklahoma 1955, seeking institutional practice. LW-33

Physicians Wanted

Special Openings—

Specialist in the following fields: Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practitioners. 58-bed fully accredited general hospital with 91-bed addition recently completed. Modern new office space available. PW-20

Pediatrician, Internist, and ENT specialist to join a well-established group practice in a community of 40,000 in East Alabama. The community has a 125-bed accredited hospital, 32-bed extended care facility. Good transportation on interstate with quick access to metropolitan area. Will pay travel expense for interview. PW-20-1

Opportunity for ENT, Internal Medicine, and Orthopedic Surgery practitioners to join partnership at clinic located in city of 38,000 population in trade area of 150,000 population in northeast Alabama. PW-20/2

Position for full-time industrial practice at textile plant with 2,400 employees at Decatur, Alabama. PW-20/3

Internists, Board-certified or eligible. One needed now and another in 1 or 2 years. For early partnership with internist in south Alabama city of 40,000 plus population. New office building adjacent to 181-bed hospital. Practice largely hospital in-patient and Cardiology. PW-21

Opportunity for a Board certified or eligible surgeon to be associated with a Board surgeon in city of 150,000 population. PW-21/1

Opportunity for physician interested in joining a progressive public health tuberculosis control program working in Birmingham, Jefferson County. Provide outpatient medical services and some administrative duties. Fringe benefits and salary open. PW-22

Obstetrician-Gynecologist—

Excellent opportunity for a trained Ob-Gyn man who would join a three-man partnership practice in city of 30,000 population located in southwest Alabama. Salary is proposed for the first 12 months, a limited partnership to begin at the end of twelve months, and full partnership to begin at the end of 24 months. PW-25

General Practitioners—

Opportunity in town of 4,000 population in trade area of 50,000 population, located within 100 miles of two metropolitan areas in south Alabama. Industrial and farming area. 44-bed hospital. Office space and equipment available in new building with another physician. Several churches, schools, and service clubs. PW-1

For community of 1,500 population located in south Alabama near city of 12,000 population. Hospitals located within 25 miles. Office space and equipment available. Farming, cattle and textile industries in the area. Several churches and school. Civic clubs and golf courses. PW-1-1

For town of 10,000 population in county of 40,000 population located in scenic mountainous section of Northeast Alabama. Office space and equipment available. Hill-Burton hospital-nursing home. Expanding industries in top agricultural area. PW-1-2

For community of 2,000 population, plus large trade area, located in Southeast Alabama. Modern clinic, fully equipped. PW-1-3

Opportunity in port town of 1,000 plus population in population center of 10,000 located in Southeast Alabama. Clinic available. Hospital located less than 20 miles away. Recreational advantages for water sports. Expanding industrial and farming area. Churches and schools. PW-1-4

For town of approximately 1,000 population in Northwest Alabama, near Tennessee Valley waterways. New 15-bed clinic available. Centrally located near metropolitan areas. Extensive industrial developments. PW-1-5

For town of 12,500 population in trade area of 50,000 located in South Alabama. Nearest large city with population of 145,000 is 80 miles away. Two hospitals with 140 beds. Numerous small industries. Several churches and schools. Recreational activities include water sports and golf course. PW-1-6

(Continued on Page 13)



Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive—Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfonamides.
Precautions/Side Effects: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.
Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. Today's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Solerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

AVC CREAM (aminocrine hydrochloride 0.2%, sulfonilomide 15.0%, allontoin 2.0%)

SUPPOSITORIES (aminocrine hydrochloride 0.014 Gm., sulfonilomide 1.05 Gm., allontoin 0.14 Gm.)

TRADEMARK A V C

AV839A 8/68

in trauma

new Orenzyme® Bitabs

One tablet q.i.d.

Trypsin: 100,000 N.F. Units, Chymotrypsin: 8,000 N.F. Units.; equivalent in tryptic activity to 40 mg. of N.F. trypsin

DOUBLE STRENGTH



Proteolytic enzyme therapy specifically indicated for the rapid resolution of inflammation and edema as adjunctive therapy in accidental and surgical trauma.

1 tablet q.i.d. provides recommended therapeutic dose at lower cost.

A FULL DAY'S DOSAGE

Description: ORENZYME BITABS offers the therapeutic effects of trypsin in an oral form as adjunctive therapy for the rapid resolution of inflammation and edema. ORENZYME BITABS is convenient to use, promotes patient cooperation and is ideally suited for maintenance therapy following parenteral trypsin.

Indications: When used as adjunctive therapy for the rapid resolution of inflammation and edema, good results have been obtained in:

- ☐ Accidental Trauma
- ☐ Postoperative Tissue Reactions.

Other conventional measures of treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.

Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.

Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.

Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reported but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.

Dosage: One tablet q.i.d.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

TRADEMARK: BITABS U.S. PATENT NO. 3,004,893 4/69 0-821A

Physicians Wanted

(Continued from Page 10)

General Practitioner to join partnership in town of 3,000 population, plus trade area of 20,000 population in northwest Alabama. Modern office building with six examining rooms. Full partnership at beginning of third year. New 30-bed Hill-Burton hospital. Salary open. PW-1/7

Opportunity in community of 3,000 population with over 8,000 population in trade area, near metropolitan area in northwest Alabama. Clinic and office equipment available. New 400-bed hospital and older hospital, and several nursing homes. PW-1/8

For town of 2,000 population in trade area of 7,000 population located in west Alabama. Physician recently died. Nearest city is 30 miles away. Medical facilities include Hill-Burton hospital and nursing home. Churches, schools, civic clubs, and recreational advantages. PW-1/9

For town of 1,800 population located in southeast Alabama in a population center of 10,000 population. PW-1/10

For town of 7,000 population located in population center of 15,000 population located in northeast Alabama. Office space and equipment available. Hospitals located in adjoining towns within 12 miles. State University located in the town. PW-1/11

For town of 2,500 population located in northeast Alabama. 17-room modern brick clinic fully equipped. Hospital nearby. Excellent schools and recreational advantages, water sports. PW-1/12

For town of 2,500 population located in northwest Alabama. 55-bed hospital being completely renovated, and an adjoining 69-bed nursing home. PW-1/13

Opportunity for group practice in town of 10,000 population in north Alabama. PW-2

Physician wanted to join 39 year old Medical College of Alabama graduate in a well established general practice in West Central Alabama town. Salary initially followed soon by full partnership. PW-3

Opportunity in community of 5,000 population in trade area of 30,000 population located in northeast Alabama where at present time there are only two active full time general practitioners. Modern offices or clinic facilities available. 48-bed accredited hospital and 52-bed skilled nursing home adjoining the hospital. Cities of approximately 75,000 population located within 25 miles distance. Agricultural and expanding industrial area. Numerous churches and schools. Country club and golf course being developed and water sports and outdoor activities offer recreational advantages. PW-4

Physician wanted to join well established partnership in Northwest Alabama city of 15,000 population. Two accredited hospitals, junior college, schools, churches, recreational activities. No obstetrics or surgery. New office building. PW-7

For city of approximately 15,000 population in north Alabama, with trade area of approximately 45,000 population. Hospital with over 100 beds, and expansion planned for next year. Nursing homes in the area. Industrial growth and agricultural region. Several churches and schools. Golf course, civic and fraternal organizations. PW-8

For partnership practice in clinic in town of 2,000 population in area of 10,000 population located in north-central Alabama. 40-bed hospital. PW-9

For assistant or associate in clinic located in town of 10,000 population located in northeast Alabama. 65-bed Hill-Burton hospital. PW-10

For associate practice in city of 6,000 population in area of over 10,000 population located in East-central Alabama. PW-11

For solo practice in county clinic located in East-central Alabama. Office, equipment and housing available. 70-bed Hill-Burton Hospital and 22-bed nursing home. PW-12

For town in southwest Alabama, approximately 1,000 population in trade area of approximately 5,000 population, within 60 miles of large city of 35,000. Nearest hospital is located 18 miles away. Arrangements available for office space. Small industries and agriculture. Civic clubs and golf course nearby. Churches and school. PW-13

For town of 1,000 plus population in west-central Alabama in trade area of 20,000. Clinic available. Nearest city of approximately 70,000 population is located a distance of 17 miles. Farming, cattle, timber, and manufacturing plants are principal resources of the area. Churches, schools, and recreational advantages. PW-15

Opportunity for general practitioner to join a five-man group, practicing as a partnership. Each man in the group is either specialized or semi-specialized. The practice is physically located within a 70-bed hospital. Willing to pay qualified person $36,000 for the first year, with possible partnership status in one year. Would consider a physician for locum tenens for three to six months at $2,000 per month. PW-16

For town of 3,600 population in trade area of 5,000-7,000 within 100 miles of two large cities and the Gulf Coast. 50-bed hospital located in the town. Office space available. Agricultural and expanding industrial area. Several churches and two schools. Recreational activities in the town as well as nearby—golf course, hunting and fishing. PW-17

Unusual opportunity for two general practitioners with military obligations satisfied at a modern fifty bed facility located 15 minutes drive from largest metropolitan center in north-central Alabama. Construction of a new two-story office building is scheduled to begin soon. PW-18

Opportunity in city of 5,000 population located in Northeast Alabama in trade area of approximately 10,000 population. Office space available. One physician died recently. Hospital and nursing home in the city. PW-19



Editorial COMMENT

There Is A Hidden Threat To Public Health In Chiropractic Bills

The fate of four bills liberalizing the regulation of chiropractic may well be decided by the time this issue of the *Journal of the Medical Association of the State of Alabama* goes to press.

But they will continue as an example of why eternal vigilance is the duty and responsibility of every Alabama group concerned with the public health. *On the surface* they present themselves not only as innocuous but as removing unfair shackles from an "oppressed" group.

Is such a position tenable? Is it professional prejudice that leads the practicing physician to oppose the practice of medicine by those unprepared and untrained in the practice? Is it any doctor's business when a nondoctor would prescribe for the ill and injured? Isn't it bad taste when he voices disapproval and opposition?

Do these questions answer themselves? Would an association of licensed airplane pilots, subject to continual observation and periodic reexamination, violate good taste in objecting to an amateur at the controls of a passenger-carrying plane? Would a nonswimmer be appointed lifeguard at a public pool? Is the cost of an astronaut's training wasted?

It comes right back to a matter of common sense. The amateur pilot may be a very good lawyer. The would-be astronaut may be praised for his courage. The volunteer lifesaver may be the most popular member of the country club. And the chiropractor may bring to the healing arts enthusiasm, self-confidence, and an astonishing familiarity with *segments of the backbone.*

But none is qualification for the broader responsibility.

And the fact that chiropractors have had elements of seeming success in their treatment of disease is no more a reason for lifting restraints than are like elements to be cited by "Christian Science" practitioners or faith healers.

Actually, one of the bills broadening the areas of chiropractic examination would seem in open conflict with the profession's own definition of the theory of chiropractic. This is the inclusion of bacteriology to a philosophy that "is based upon the premise that disease or abnormal function is caused by interference with nerve transmission and expression," a condition corrected "by an adjustment with the hands of the abnormal deviations of the bony articulations of the vertebral column."

Among other added areas are "chemistry, pathology, gynecology, X-ray, geriatrics."

Another bill provides a "grace period" of a year following graduation in which a chiropractor may practice in Alabama before meeting the state's licensure requirements, which consist largely on examination before a board of fellow chiropractors.

And what is medicine's responsibility? One might quote from the pronouncement of the American Medical Association, made at its first meeting, 122 years ago:

"Physicians, as conservators of the public health, are bound to bear emphatic testimony against quackery in all its forms."

The 'Scarecrow of Oz' Was Born Two Generations Too Soon

You'll remember the lament of Baum's happy creation: "If I only had a brain!"

And the Tin Woodman wanted a heart.

Both are being provided by the inventiveness and imagination of 20th century Man, a brain of metal and a heart of plastic. Naturally, the two make mistakes; for "to err is human," and after all both are the creations of homo sapiens.

The computer, sometimes called the "mechanical brain," is functioning in every facet of our lives today. It is solving the problems of business and industry. It is prophesying the outcome of elections, mapping the course of vehicles into outer space, and handling magazine subscription lists, all in less time than it takes to say: "Jack Robinson!"

Today, like an all-powerful Zeus ordering from Olympus the destiny of mankind, the computer is looking over the patients at Pacific State Hospital, picking out this one, that one, and another, and saying in effect:

"These should die within a few months."

But unlike the worshippers of Zeus, who bowed dejectedly to the inevitable, medical science is circumventing the computer's prophecy of doom. Physicians at Pacific State Hospital use the computer to ascertain which ones among their patients run a relatively high risk of death in the early months after admission, so that this fore-gained knowledge may help prevent death.

This hospital, devoted exclusively to the treatment of the mentally retarded, has noted that patients with certain characteristics were more likely to die while hospitalized than others, especially within the first few months after admission.

The value of the computer, said Richard K. Eyman, Ph. D., a psychologist and director of computer operations at the hospital, "is that it does not miss anything. In the course of admitting patients, a human could miss a relationship between certain symptoms. But the computer will not—if it has been properly programmed . . .

"When we began this study, we found 133 per thousand of young, low-IQ children were dying within six months of admission. With the computer's help, we reduced this figure to 23 per thousand in ten years, by sending these projections to the hospital staff."

Finding that 13% of the children died within six months of admission and that 20% died within four years, Dr. Eyman commented: "We believe one of the causes of this may have been the shock these children experienced in being taken from the atmosphere of the home and being placed in the hospital—coupled with the fact that their physical condition usually is somewhat poor." Knowing what to look for, many doomed are being saved.

So, as certainly as the fantastic dreams of yesterday's science-fiction writers are coming true, so are the mechanical brain and the artificial heart of Never-Never Land becoming today's reality.



Competitive Spirit Injected Into Safe-Driver Contest

One of the macabre aviation jokes of World War I told of the flying instructor who started the student pilot down the runway on his first solo into the wild blue yonder, only to snap his fingers in sudden wonderment and exclaim:

"I told him how to take off, and how to fly. But bedamned if I didn't forget to tell him how to land!"

We're very busy these days instructing everyone from 16 up how to drive a car around a city block and parallel park between two other cars. We caution about the importance of keeping gas in the tank, water in the radiator, and air in the tires.

There's a free booklet from which to memorize enough of the rules of the road, the traffic signals to make, and the speed limits to observe, to pass the examination for a driver's license.

But, bedamned if anyone is coached in how to merge on a 70-mile-an-hour freeway, or to control his vehicle in an emergency situation.

One group of concerned Americans has launched a program that approaches the problem from a novel angle and may prove a device for saving lives on the crowded traffic arteries of the nation.

Operation Driver Excellence is the name of the program, and sponsoring it is the American Veterans of World War II, Korea and Vietnam (AMVETS), in collaboration with the Dodge Division of Chrysler Corporation. Earlier this summer, finalists from 23 states and the District of Columbia met in Detroit to compete for more than $5,000 in scholarships and prizes.

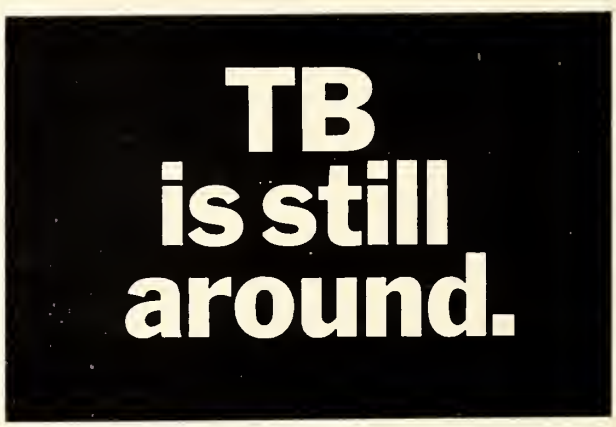
Competitors were in the age range of 16 to 18, and there was a four-phase plan of contests. It began with a written examination.

The second phase was a closed-course event, similar to state competition, designed to test handling, stopping and parking abilities on an elapsed time basis.

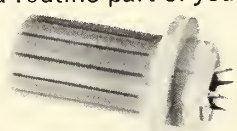
The third phase of the national event was designed to test the contestants' expertise under actual traffic conditions. With a police officer acting as judge, the student competitor was put through a pre-determined course involving surface street, intersection and through-way traffic problems.

And the final phase concerned the handling of a vehicle in an emergency situation. This was carried out by the contestant building the car to a specified speed and then at a surprise signal locking the brakes and controlling the car in a skidding condition.

It seems a positive step forward in promoting driving skills in this age of speed and crowded highways.



In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9

Chiropractic Condemned In Stinging JAMA Editorial

Medicine always has considered its mission as twofold: to advance the science and art of medicine and to protect the public health. Within this latter context medicine has waged its unrelenting attack on quackery in all its forms. At its first meeting in 1847, the AMA specified that mission when it stated: "Physicians, as conservators of the public health, are bound to bear emphatic testimony against quackery in all its forms."

And, since chiropractic's questionable birth in 1895, medicine has not wavered in its stand that it is an unscientific cult. The AMA's House of Delegates in 1966 adopted a policy statement that detailed that stand: "It is the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to treat human disease. Chiropractic constitutes a hazard to rational health care in the United States because of the substandard and unscientific education of its practitioners and their rigid adherence to an irrational, unscientific approach to disease causation."

Numerous other health-related groups have adopted the same or similar policy statements, but until recently the effort to inform the people about the evils of chiropractic has been made almost exclusively by medicine—an effort which, despite all of medicine's attempts to be objective and factual in its findings, was subject to what the chiropractors have chosen to call "self-serving declarations."

That situation now has changed.

In the social security amendments adopted in 1967, the Congress ordered the US Department of Health, Education and Welfare to make a study of the so-called independent health practitioners, including chiropractic, and to report the results of that study to Congress. That study was conducted by HEW —an unbiased, independent study— and the report by HEW of the chiropractic study, sent to Congress in January 1969, is a devastating indictment of chiropractic. HEW flatly recommends continued exclusion of chiropractic services from those provided under the Medicare legislation.

The conclusions of the report made by HEW contain these statements:

"1. There is a body of basic scientific knowledge related to health, disease, and health care. Chiropractic practitioners ignore or take exception to much of this knowledge despite the fact that they have not undertaken adequate scientific research.

"2. There is no valid evidence that subluxation, if it exists, is a significant factor in disease processes. Therefore, the broad application to health care of a diagnostic procedure such as spinal analysis and a treatment procedure such as spinal adjustment is not justified.

"3. The inadequacies of chiropractic education, coupled with a theory that de-emphasizes proven causative factors in disease processes, proven methods of treatment, and differential diagnosis, make it unlikely that a chiropractor can make an adequate diagnosis and know the appropriate treatment, and subsequently provide the indicated treatment or refer the patient. Lack of these capabilities in independent practitioners is undesirable because: appropriate treatment could be delayed or prevented entirely; appropriate treatment might be interrupted or stopped completely; the treatment offered could be contraindicated; all treatments have some risk involved with their administration, and

Reprinted from JAMA, April 14, Vol. 208, No. 2.

inappropriate treatment exposes the patient to this risk unnecessarily."

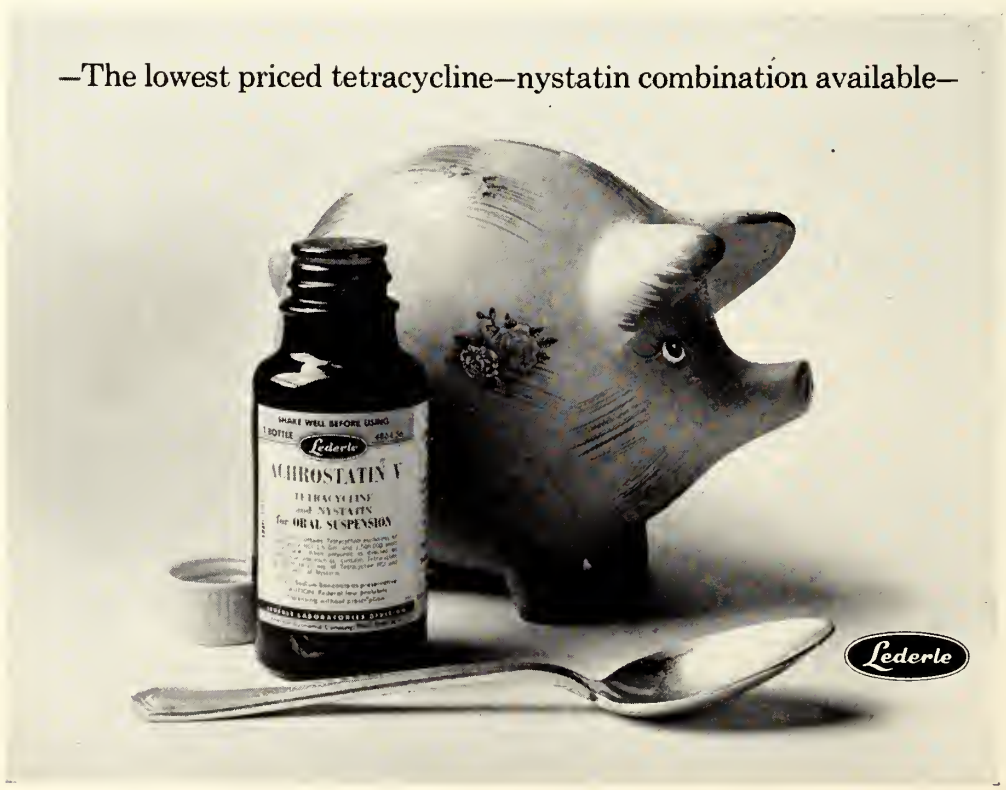
HEW's recommendation to Congress reads as follows:

"Chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease, and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment. Therefore, it is recommended that chiropractic service not be covered in the Medicare program."

There has been another recent development. The National Council of Senior Citizens is an organization composed of 2,500,000 persons 65 years of age or older—the Medicare recipients themselves. It publishes a monthly newspaper called the *Senior Citizens News*. In its January 1969 issue, it published an article on chiropractic that is even more devastating than the HEW study report.

These two major weapons from outside medicine join a third of equal importance—the federal court decision in the England case, which was affirmed by the US Supreme Court in 1966. That decision, by the highest courts in the land, holds, in effect, that, since chiropractic claims competence in the diagnosis and treatment of the broad gamut of human disease, a state has the right to refuse to license chiropractors unless they meet the same qualifications as do doctors of medicine.

In fulfilling their obligation to protect the public health, all physicians have the duty now to call these pronouncements to the attention of the public. In fact, all in the scientific community share this responsibility.



Therapeutic Orphans

By an odd and unfortunate twist of fate, infants and children are becoming "therapeutic or pharmaceutical orphans."[1] Since 1962 they have been denied the use of many new drugs. The Drug Laws of 1962 had their inception following a pediatric tragedy—the thalidomide catastrophe. The laws of 1938 followed another which resulted from the use of a pediatric dosage form, "elixir" of sulfanilamide. By "legal" definition, drugs introduced since 1962 must be safe and efficacious, but only a small number of these have been studied in the pediatric age group. Certainly, there are some drugs which have an anticipated use only in adults; it would be unreasonable to ask for certification of these for use in infants and children. There are a small number of new drugs, released since 1962, which had an anticipated use for infants and children as well as for adults, and their applications for approval have been passed after the required studies in pediatric and adult patients. However, many of the drugs released since 1962 carry an "orphaning" clause, e.g., "Not to be used in children, . . . is not recommended for use in infants and young children, since few studies have been carried out in this age group, . . . clinical studies have been insufficient to establish any recommendations for use in *infants* and *children* . . . should not be given to children."[2, 3]

Despite such clear cautions, many physicians have ignored the warnings and have prescribed the restricted drugs. It requires little imagination to wonder what a jury of laymen would decide after a defending physician admitted in court to the use of a drug despite such a clear warning.

Although the laws were designed to ensure the efficacy and safety of drugs, *the age group responsible for their passage* is now often deprived of the use of the medications. Testing of these drugs cannot always be in controlled situations, but is sometimes in the situation of use—by ordeal and often against advice. Inevitably this "unlawful" procedure will be associated with some adverse reactions, including toxic reactions, side effects, and idiosyncrasy. These reactions are common to all drugs. History has also taught that drugs previously considered harmless may be associated with temporary and permanent reactions unique to the newly born infant; even oxygen falls into this category.

It seems unfair that the use of some drugs will be denied on the basis of relatively infrequent use and small sales potential. For example, should a child with peptic ulcer be denied the advantages of a drug which is proved to be of value to adults because that drug has not been tested in the pediatric age group? Other examples could be mentioned relative to diseases of greater frequency, but in which the needs for drugs fall below the anticipated sales volume required to warrant study in children. After cursory consideration one might place the blame for this growing problem on the drug industry alone. However, many groups are responsible including the government (especially the Food and Drug Administration), the academic pediatric centers and practicing physicians.

The pharmaceutical industry in the past has supplied many "service items" and will continue to supply these at a financial loss, although it would prefer to supply drugs for a large and profitable market. However, pharmaceutical firms have difficulty finding a sufficient number of clinical investigators with interest, experience, and patients for the study of new drugs. These difficulties are inversely proportional to the frequency of the disease and to the age and size of the patient. Yet it is quite clear that those who desire better drugs must inevitably include clinical investigation of drugs among their responsibilities. The Food and Drug

Reprinted from The Journal of Pediatrics, St. Louis. Vol. 72, No. 1, Pages 119-120, January, 1968. (Printed in the U. S. A.) (Copyright © 1968 by The C. V. Mosby Company)

Administration has statutory responsibility for ensuring that drugs are safe and effective. It cannot have different criteria for depth of study of drugs intended for adults as compared with those for infants and children. It recognizes, as does industry, an increasing reluctance on the part of pediatricians and others treating children to investigate the effect of drugs in the pediatric age group. At the same time the Food and Drug Administration discouraged such studies by their interpretation of the law into guidelines which clearly indicated that written consent of patients (or their representatives) had to be given "except in unusual circumstances." The guidelines lacked clearly defined limitations, or provisions specifically outlining requirements for studies in infants and children. This interpretation has been changed, easing the difficulty somewhat and demonstrating that reasonable cooperation can be effected. However, the climate created by present regulation of human experimentation makes drug testing difficult, and especially so unless a warm and close relationship exists between the doctor who gains the permission and the parent or guardian who grants it. The continuing close patient-parent-doctor relationship existing in the private practice of medicine may permit a greater ease of meeting these legal requirements.

The Food and Drug Administration recognizes the responsibility of industry to provide adequate directions and accurate dosage for use of drugs in children; likewise, it recognizes the difficulties encountered in gaining this information. It also recognizes a pressing public issue developing in the face of the above difficulties. It is trying to face the problem and to develop positive attitudes; for instance it has recently sponsored a Conference on Pediatric Pharmacology.

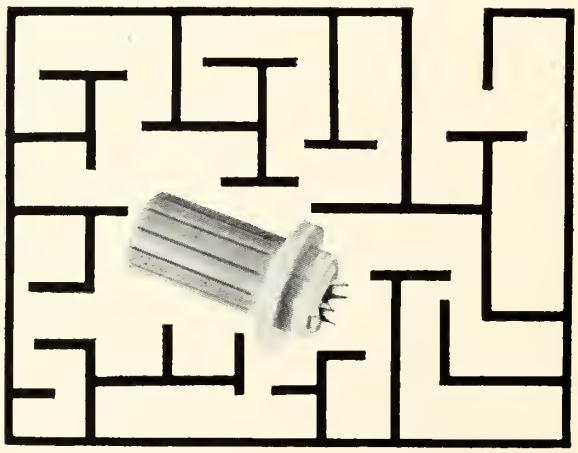
Every practicing physician, especially pediatricians and pediatric surgeons, departments of pediatrics, and departments of pharmacology should closely examine their own capacities and performance in this area of greatly needed activity. If we are to have drugs of better efficacy and safety for children, those responsible for child care will have to assume this responsibility for developing active programs of clinical pharmacology and drug testing in infants and children. The alternative is to accept the status of "Therapeutic Orhpans" for their patients.

References

1. Shirkey, H. C.: Conference of Professional and Scientific Societies, Chicago, June 27-28, 1963 (sponsored by Commission on Drug Safety, Chicago, Ill.).

2. New Drugs, 1967, The American Medical Association, Chicago, 1967.

3. Physicans' desk reference to pharmaceutical specialties and biologicals, ed. 21, Oradell, N. J., 1967, Medical Economics, Inc.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST
(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York
473-9

One of these disposables comes prefilled.
Its unit dose – in nonreactive glass cartridge – is premeasured.
The cartridge is clearly labeled:
drug name, strength, control number.
Even expiration date where appropriate.

You're more confident that the patient gets...





. . . just what the doctor ordered with the Tubex Closed Injection System.

Injections with the Tubex system are as easy as 1, 2, 3,

1. Select—from an extensive variety of prefilled Tubex sterile cartridge-needle units.* No multi-dose vials to bother with; no unlabeled syringes to cause confusion.

2. Inject—with a minimum of pain. Thanks to the single-use, stainless-steel needle that's both ultra-sharpened and siliconized. Aspirate simply and conveniently.

3. Throw away—empty cartridge-needle unit. Never used again, it can't transmit infection. And there's no clean-up job.

*For injectables not yet in the ever-expanding prefilled Tubex line, empty sterile cartridge-needle units are available.

TUBEX®

Closed Injection System
Hypodermic Syringe
Sterile Cartridge-Needle Unit

Wyeth® UD UNIT DOSE MEDICATION™

Wyeth Laboratories Philadelphia, Pa.

Behavior Modification Institute

Jane Marxer

Montgomery, Alabama

Program participants gathered from coast to coast at mid-May, for a "Behavior Modification Institute" at Tuscaloosa, one of the first of its kind in the nation.

The three-day event at Ramada Inn attracted a capacity enrollment of 352 mental health professionals. "We could probably have registered 800 people for this institute," its chairman, Joseph A. Whitener, Tuscaloosa, said. Applications were received from seven Southern states, but only a limited number were accepted outside Alabama. Many were turned away.

"This is the kind of program we are exceedingly pleased to see developed," said Dr. Robert Garber, Washington, D. C. In bringing greetings from the American Psychiatric Assn., Dr. Garber, its president-elect, also expressed approval of the coalition of cosponsors: the Tuscaloosa Veterans' Administration Hospital, the Alabama Department of Mental Health and the University of Alabama Medical School, Department of Psychiatry.

Mental Health's Third Revolution

"Behavior Modification—a Third Revolution in Mental Health," was the title of a general overview by Dr. Daniel Brown, Atlanta, during the opening session. Dr. Brown, a mental health consultant with the U. S. Department of Health, Education and Welfare, explained that the first revolution was the work of Philippe Pinel, Parisian psychiatrist whose influence freed mental patients from forcible restraint, during the 19th Century. The second reference was to the work of Sigmund Freud.

The third, behavior modification, is not associated with the name of a person, but with a collection of developments that have taken place over the past 50 years. Dr. Brown described the latest advance as "the systematic application of learning of principles and conditioning to the modification of deviant behavior." (Examples of these methods, involving reward for good behavior, may be seen at the Tuscaloosa Veterans Administration in attitude therapy, and at Bryce in the token economy system.)

He predicted that in the treatment of mental illness, increasing numbers of therapists will focus more on the present environment than on past history. More attention will be given to symptoms than to the conditions responsible for the disorder.

Some of the questions to be asked are: (1) What is the behavior that should be changed —mutism, autistic, acting out, disruptive, fearful, etc.? (2) Rate or frequency? (3) What are the current environmental conditions that could be changed? (4) How can the behavior be modified?

He explained that "mental illness" actually describes ways in which a person has learned to cope with his environment. The focus in the traditional approach has been on overt behavior, on reconstructing the past history of an individual. Now it is on careful analysis of present history and observable internal behavior.

"We are not saying that this behavior approach is a panacea to solve all the mental health problems," Dr. Brown said. But he said it has been seen to bring about changes in behavior problems previously not amenable to intervention.

He named these advantages: (1) Greater effectiveness as a treatment method. (2) Less time and fewer sessions needed. (3) Goals more specific and can be established from the

beginning. (4) Greater applicability to a wide segment of population. (5) Can be used by a wide variety of health-giving individuals.

Since the techniques can be carried out by many groups of people, behavior modification has enormous applications to the manpower problem, Dr. Brown pointed out. "There are literally thousands of children with emotional and behavioral difficulties for every single mental health professional," he said.

In the United States, between seven million and 15 million children and youth have problems sufficiently disturbing that they need assistance. Of the helping groups that can provide this aid through behavior modification methods, Dr. Brown said that perhaps the two most important are teachers and parents.

"Given the proper training, instruction and backup service, these techniques can be applied and carried out by helping groups. This is in contrast to more traditional use in the past, where only a person with advanced training could actually work with an individual with disturbed behavior," he said.

Dr. Brown predicted, however, that resistance to the new methods will arise, just as it did to the efforts of Sigmund Freud to understand the human mind. "They will say that you are only substituting one symptom for another. They will say it is dangerous and a form of brain washing," he said. "It should be regulated, as any other tool that a member of the helping profession is given. If it is not ethically used, it can certainly do some damage, and that goes without saying."

Dr. Brown said that most training programs in the mental health disciplines have not included basic behavior modification in the training curriculum. He said that the regional office of the Department of Health, Education and Welfare will do as much as it can to provide assistance, beginning with a library of fundamental readings in this area.

Applied To Different Settings

"Behavior modification has not been confined to a restricted range of disturbed people," said Dr. Brown. His statement was supported by the variety of applications to be described by the scheduled speakers. Included were:

Dr. Halmuth Schaefer, research psychologist, Patton State Hospital, Patton, Calif.; Dr. Robert Heap, director of clinical training, Central State Hospital, Milledgeville, Ga.; Dr. John McKee, executive director, Rehabilitation Research Foundation, Elmore, Ala.; Dr. Muriel Oberleder, chief psychologist, Bronx State Hospital Geriatric Service, New York, N. Y.; and representatives of the sponsoring agencies.

Speaking on "Training and Research in Behavior Modification," Dr. Schaefer showed film illustrating how long-range schizophrenics are remotivated by payment in tokens for desirable behavior changes. Although charged tokens for their meals, the patients have never been in danger of not earning enough to ward off starvation, the speaker declared.

"The patients do not like the system at first, because we make a lot of demands that they do things for themselves. Gradually, we demand more. As the patient achieves success, he enjoys functioning in such a system," said Dr. Schaefer.

He, too, remarked on the ethical problems underlying behavior modification techniques. He raised the questions: "Do we have the right to impose our standards on these patients? If so, what standards do we impose? Do we have the right to prevent a patient from withdrawing from an environment from which he can't cope?"

Planning, Implementation Advice Given

"Planning and Implementing a Behavior Modification Program" was the topic of Dr. Heap, based on experiences at Milledgeville. "One of the first orders of business is to establish good avenues of communication and

cooperation, vertically and horizontally," he said. "By vertical comunication, I mean information passing up and down the chain of command. If this communication system is faulty, you will discover that conflicts arise, and in the end, it is always the patient that suffers."

He said that every discipline must be aware of its precise role, and the extent of its involvement, stressing again the importance of inter-communication.

Also of first importance is the training of attendants, who have been redesignated "behavioral technicians," and who maintain the program operations. They need to understand how the program will work—its short and long-range goals, and how it will pay off for them and for the patients. The training period should last as long as necessary, and personnel should be tested from time to time, after it is completed.

Another consideration is money. "You must insure that you have at least adequate funds in your budget to maintain a ward store," said Dr. Heap. The store is stocked with items patients can buy with tokens they have earned.

Dr. Heap described a behavior modification ward, operative for 35 months, with an overall program embodying a token economy program, an attitude therapy program, a ward government program and group sessions conducted by behavior technicians. The patients must work, participate in recreational activities and display positive social behavior in order to earn tokens.

He said, "In an operation such as ours, nothing should be left to chance. Therefore, patients should always be bombarded with information." A daily schedule is posted, so that they know what is going on about them at all times. They are constantly reminded that there are appropriate ways of having their needs met.

"We feel that through our behavior modification programs, we have redefined the term, 'patient'," said Dr. Heap. "A patient is now appropriately aggressive and independent, and actually participates in his own and others' treatment."

He said that of 478 patients, 74 per cent have returned to their communities. The relapse rate has been only 14 per cent over the last 35 months.

Reactor Panel Heard

During a reactor panel, Dr. John McKee said that behavior modification techniques could reform, overnight, Alabama's prison system.

"I am proposing that we do a joint project one of these days in intervening with a predelinquent group of junior high school boys. What we will want to do by way of general objectives is to provide some significant success experiences for them," he said.

Another panelist, Dr. Muriel Oberleder, said of geriatric patients: "Maybe if we paid our patients to learn new skills, we could get some of them out." She said she plans token rewards for elderly people who are willing to learn new social skills, particularly the art of conversation; and those who go to community social clubs to learn to interact with people.

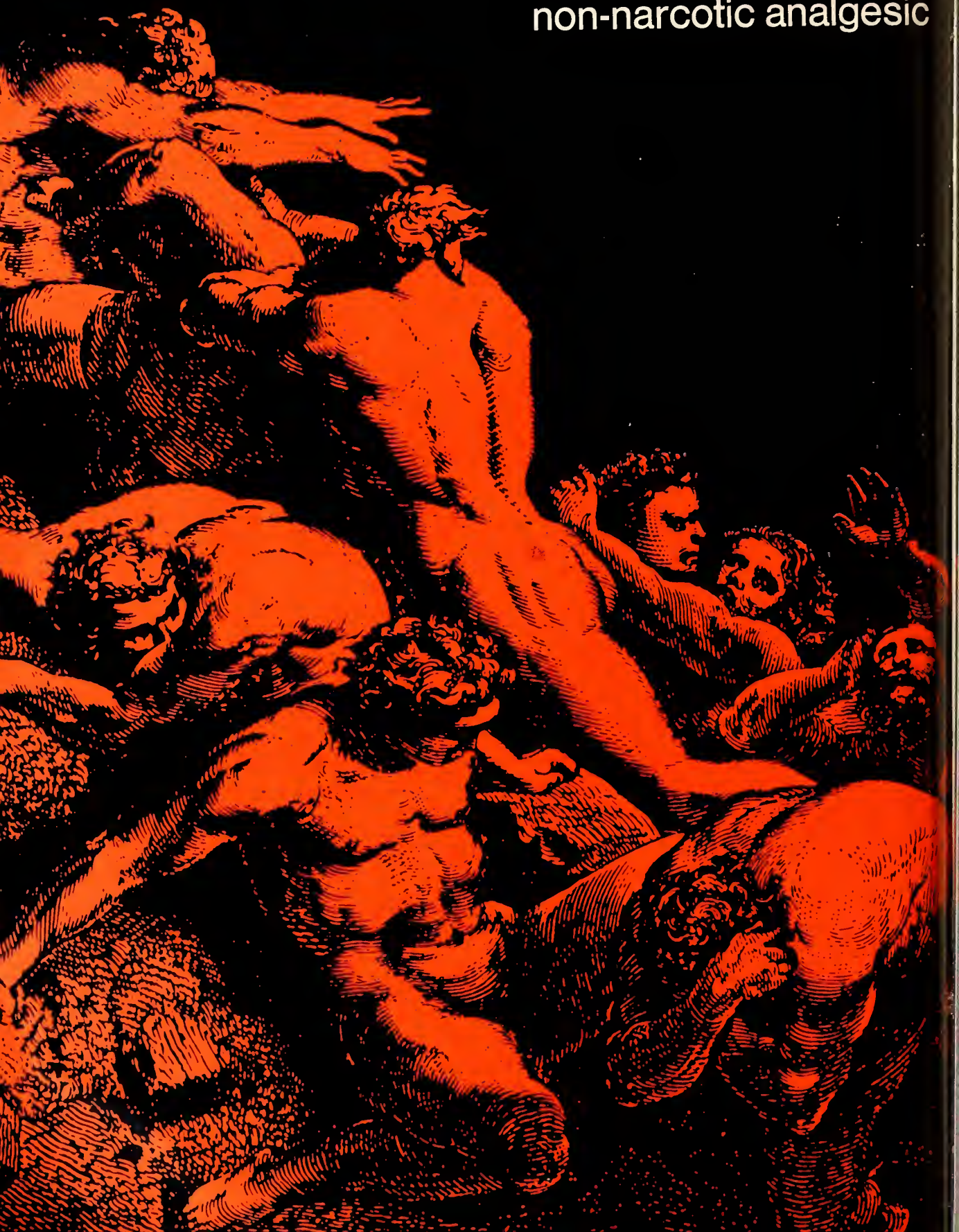
Mrs. Roberta Ray, also on the panel, said she believes a training series for community professionals is ". . . just as important as talk-to our computers." She said a training course for Oregon school teachers is being planned for those with problem children in their classrooms. "Teachers know more about teaching than we psychologists do, so why not put it where it should be?"

Dr. Schaefer recommended an annual institute as an established procedure, stating it can make an impact on policy at a very high level. Plans are already underway for such an institute in Alabama for 1970, with the University of Alabama School of Social Work and the Alabama Association for Mental Health joining the sponsors of the recent event.

NORGESIC®

(orphenadrine citrate, 25 mg., aspirin, 225 mg., phenacetin, 160 mg., caffeine, 30 mg.)

non-narcotic analgesic



For musculo-skeletal pain,

try Norgesic first...
8 of 10 patients probably won't need anything stronger

Norgesic offers predictable relief in approximately 80% of patients with painful musculoskeletal disorders. It provides *both* effective analgesia and relief of associated muscle spasm. Norgesic works quickly, usually producing a high level of analgesia within two hours, and relief is sustained for four hours or longer.

For the relief of acute mild to moderate pain associated with musculo-skeletal disorders, try Norgesic first...eight of ten patients probably won't need anything stronger.

Indications: Symptomatic relief of acute mild to moderate pain of musculo-skeletal origin.

Contraindications: Due to the mild anticholinergic effect of orphenadrine, Norgesic should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcers, prostatic hypertrophy, obstructions at the bladder neck, achalasia (megaesophagus), myasthenia gravis or in patients known to be sensitive to aspirin, phenacetin or caffeine. Do not use propoxyphene (Darvon®) concurrently.

Warnings: USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the childbearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

Precautions: Recent studies have indicated that prolonged excessive use of phenacetin may result in nephrotoxicity. Caution should therefore be exercised when administering Norgesic to patients with renal insufficiency. It should also be used with caution in patients with tachycardia.

Adverse reactions: Side effects of Norgesic are those usually associated with APC or mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, mental confusion in the elderly, mild central excitation and occasional hallucinations. These mild side effects are usually eliminated by reduction in dosage. One case of aplastic anemia, with no established causal relationship, has been reported.

Dosage and administration: Adults—1 to 2 tablets 3 to 4 times daily.

For more detailed prescribing information, see Package Circular or PDR.

NORGESIC®

(orphenadrine citrate, 25 mg., aspirin, 225 mg., phenacetin. 160 mg., caffeine. 30 mg.)

non-narcotic analgesic

Riker Laboratories, Northridge, California 91324
Div. Dart Industries Inc.

Sponsors of Riker Service—
the complimentary classified service for physicians.

MEDICAL MEMORANDA

Every member of the lower house of the Congress of the United States has received a novelty ashtray from Dr. W. R. Spence, Holy Cross Hospital, Salt Lake City, who designed it. It shows two plastic lungs in action, one healthy, the other sick. It is designed to (and does!) frighten the wits out of a cigaret smoker.

* * *

The villain of the common cold (the rhinoviruses) will go before a firing squad for long-overdue execution, if hopes for the new interferon-inducing drugs, now the subject of extensive research, are fully realized. One of them, known as poly I: C, has shown high level activity against the common cold viruses in human cell culture, though it has never been studied in man.

* * *

"We just did an experiment on dogs to which even those who object to experiments on dogs cannot possibly object," writes Dr. Frank Cole in *The Nebraska State Medical Journal*, which he edits. "We had meat and cheese on a plate, and our intelligent and spoiled poodle was sitting there demanding his share; poodles do not beg, they demand. So we set up an experiment to see which he wanted more, the meat or the cheese. We chose two identical bowls and put meat in one and cheese in the other. Then we placed both in front of this fortunate dog. He proved much smarter than Balaam's ass who starved because he could not make up his mind. He went right over to the cheese (*aha*, we said); then he left it for the meat. *That* does it, we said, whereupon he left one last meat fragment and came back and ate up all the cheese, after which he finished the meat . . . It was a well-set up experiment. We did it without a grant of any kind. And what did it prove? Dogs are smarter than people."



Darvon®
Compound-65

Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

Lilly

Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206.

900252

THE JOURNAL

of

THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

Published Under the Auspices of the Board of Censors

Volume 39 July, 1969 No. 1

The Concept Of "Readiness" And Learning Disabilities

Charles L. Shedd, Ph. D.

Birmingham, Alabama

"Education is life, life is growth, education is growth," is a statement that ushered in current educational practice. Criticism was almost immediate for a definition of growth was not provided. Without it the statement was tantamount to saying "education is education."

A concept of growth was required if educational theory was to remain intact. Searching about, a model was found in physical growth. Mental development was not only seen as following the same pattern as physical development but of being determined by it. Function was determined by structure and structure was determined by growth. Education was conceived as a situation in which imminent characteristics could find expression.

Sorenson (1954) in one of the most popular educational psychology textbooks, presents a culmination of the view on mental development and growth. It is worth quoting to some length:

> "In respect to mental growth and development, certain questions arise about the change in mental powers that take place as an infant grows older day by day, month by month, and year by year. As a child is able to run faster as he grows bigger and stronger, similarly does he learn to read faster because his nervous system grows and develops? Can a child from the mere fact of becoming older, solve harder arithmetic problems than formerly? As children become older they increase in height and weight and acquire more skill and power in playing with a football or basketball. Correspondingly, do they also acquire a larger vocabulary and ability to use more words because the nervous system grows and develops? Does a child as he grows older develop a better memory, does his reasoning power improve, and does his imagination become more effective? Can he perform mental tasks more rapidly and more difficult ones? Do mental powers increase because of the neural growth that accompanies an increase in age?
>
> "The answers to all these questions are in the affirmative. As the child grows older from infancy to maturity, his mental powers do increase. This growth in mental capacity is caused by the growth of its parts in general, but more particularly by the growth of the nervous system . . .

"If a child were deprived of all experience, say for a period of two years, would he increase in capacity? Imagine a child of seven anesthetized in effect except that he took nourishment and grew according to his potentiality but without activity. The point of this illustration is to bring up the question of whether or not he would have increased in capacity after two years of inertness. In other words, does growth alone increase capacity and power?

"The child would increase in capacity even though he had no experience. When he 'awoke' he would be bigger and stronger because his nervous system would have grown and developed, too. When he resumed activity, he would have lost from his 'vacation' from experience but he would have more capacity for development and would make more rapid progress than he did two years before. . ."

The role of the educator was to determine the position on the growth curve for each student and to adjust instruction to his level of mental maturity. This level of mental maturity was termed "readiness" in relation to a specific task. Whether the child should be accepted into the school program and if accepted whether he should undertake a given task was dependent on his "readiness."

Most schools developed programs to evaluate children at first grade entrance for reading readiness. Tests were given which were believed to contain items which have some relation to the acquisition of skill in reading. The tests usually contain items on visual and auditory discrimination, motor control, verbal comprehension, range of vocabulary and general information concerning the developmental histories and backgrounds from which children come. It is suggested that this might best be accomplished through questionnaires and parent interviews. Observations should be made if possible by the teacher to determine whether the child has stable habits of attention, ability to continue working in the face of a task or difficulty, ability to speak with ease and freedom, accuracy in enunciation, etc.

If a child comes out poorly on such an evaluation it is concluded that he is immature. One of two courses of action then is ordinarily followed: (1) the child is admitted to the educational program, but placed in a low achieving or late "blooming" group, or (2) parents are advised to hold the child out of school until maturation or readiness takes place and he is capable of learning more easily. The latter is usually good advice and worth respect from the parents, for if school holds to a growth philosophy the "immature" child may not only fail to learn to read, but may become seriously maladjusted. It may be seen that this view is based on a simple assumption that what is found in children "averagely" at a particular age level is developmentally normal. It is further assumed that the behavior patterns sampled are little modified by experience. Such views underlie the maturationist views expressed by Gesell, Piaget, Binet, and others.

Most of the support for such a view derives primarily from a study of simple motor skills and a single complex motor skill, walking. This is expressed by Ruch (1958) as follows:

"The neuromuscular structures of the body must reach a certain stage of development (maturation) before they are capable of responding to stimulation. For example, a child cannot perform a certain activity such as walking, until he has developed the physical structures necessary for the activity, regardless of the amount of training he receives."

Hilgard (1953, p. 5) points out:

"To give some inkling of the kinds of problems discussed in this section on growth and development, we may turn to questions concerning the muscular skills of children. Does a child, for example, learn to walk as a result of practice? Or is beginning to walk largely a process of biological maturation?"

He discussed the stair climbing experiment by Gesell and Thompson, presents a longish

quote which concludes, "From this experiment it is clear that growth or maturation as it is often called when the reference is to behavior is of major importance in developing the ability to climb stairs."

Ruch and Hilgard are not unusual in regard to this presentation, it is standard fare in practically every elementary psychology, educational psychology, and elementary education textbook in use today. The experiments which they and their colleagues quote, McGraw, Dennis, Gesell and Thompson, and others, are notable experimental accomplishments. They demonstrated beyond any doubt that the mechanism for walking seems to be largely one that is dependent upon growth and development independent of special training since the mechanism seems to be built into the spinal cord and lower brain centers.

The question which is critical is not whether walking is maturationally determined but whether from a number of well-conducted experiments on the nature of walking one may generalize to problems of conceptual development. It would appear more probable that development in the conceptual area would be dependent on the background of the child and would not follow a rigid pattern of development which cannot be modified through special training without any long-term results, is limited only to certain relatively simple motor skills, but more complex aspects of development can be influenced substantially through appropriate training procedures. A number of studies have been undertaken in which children at the four-year level have been trained to read, and the acquisition of the skill has not been dependent on particularly high general ability.

The overwhelming weight of evidence indicates that conceptual development and the development of complex motor skills are highly dependent upon training. Far from having to wait until the maturation process has produced a state of readiness, training in such skills seems to be a major determinant and can be undertaken with profit at an early age, even perhaps as early as the second year of life. Fowler (1962) has presented evidence in this regard from a variety of sources. It provides an impressive and welcome antidote to the maturationist viewpoint.

Beach and Jaynes (1954) reviewed literature concerning the relationship of adult behavior to early childhood experiences. They concluded that there were three ways in which infancy and childhood influence adulthood: (1) habits developed in infancy may persist into adult life, (2) early perceptual learning may influence adult behavior, (3) there may be critical periods of development.

Certainly of some consequence relative to these generalizations is the study by Passmanick and Knoblock (1960). They point out that in their study of Baltimore children almost all of those with IQ's below 80 were neurologically impaired. They also had a history of a significantly higher proportion of the chronic complications of pregnancy and a higher percentage of birth weights less than 1500 grams than other children. These findings were interpreted as meaning that measures of intelligence used in later life are greatly influenced by learning and affected by life experiences, which tend to limit opportunities for acquiring the kinds of information that the tests evaluate. They seem to question whether intelligence actually conforms to a normal distribution. Their evidence seems to support the view that outside of hereditary clinical deficiencies and for exogenous injury of neural integration, behavioral variation does not seem to be the result of genetically determined structural origin. They say: "We believe, that it is now possible to entertain a new *tabula rasa* theory which hypothecates that at conception individuals are quite alike in intellectual endowment except for the few quite rare hereditary neurologic defects. It appears that life experience and the sociocultural milieu influencing biological and physiological function, in the absence of organic brain damage,

makes human beings significantly different from each other."

Hebb (1949) has pointed out that human learning can be broken into two types, early learning and later learning. The first stage involves processes that must be mastered before complex learning can occur. This stage is concerned with learning stimulus discrimination, stimulus constancy, etc. He employs the work of Von Senden to illustrate the distinction. Von Senden studied adults who had received corneal grafts and who were able to see for the first time in adulthood. Some never learned to use their vision even though surgery had restored their eyes to the point where they were physiologically capable of doing so. All had extreme difficulty in learning to make simple form discrimination such as a triangle from a square.

Melzack (1962) followed these suggestions through by experimental study. He compared problem solving ability of dogs raised under typical circumstances with dogs that were restricted in visual experience. He found that dogs raised in normal circumstances learned the discrimination task more rapidly than those raised in a restricted environment.

Studies were carried out by Gibson and Walk, and Gibson, Walk, Peck and Tigue (1959). These studies demonstrated that chicks exposed to a circle and a triangle during the first 120 days of their lives showed superior performance on a form-discrimination problem involving these forms.

Scott (1965) has pointed out that: "Both growth and behavioral differentiation are based on organizing processes. This suggests a general principle of organization that once a system becomes organized whether it is the cells of the embryo that are multiplying and differentiating or the behavior patterns of a young animal that are becoming organized through learning, it becomes progressively more difficult to reorganize the system. That is, organization inhibits reorganization. Further, organization can be strongly modified only when active processes of organization are going on, and this accounts for critical periods of development."

Money, Hampson and Hampson (1957) studied the development of hermaphrodetic children who have been reared as one sex and then changed to the other. They find that if this occurs before 2½ years of age very little emotional disturbance results. Thus, there is a critical period for learning the sex role.

The point quite obviously might be that if a child has not had the necessary experiences to learn to read by six years of age, he may have missed the early learning experiences and training may be more difficult. In other words the notion that postponement of a task until "maturation" has progressed to the stage where the task might be easily undertaken ignores the possibility that intensive learning might be required before such skills can be acquired.

Travers points out: "Why the average kindergarten child cannot read is a complex problem. A simple explanation in terms of maturation is not adequate to cover the situation. If early learning, or lack of it, is a major fact, then we may be forced to discard the notion that the first grade is too early to begin reading—provided, of course, there has been a previous period of adequate and appropriate training. It may well be that a suitable and planned period of learning during the first few years of life might prepare a child to read at a much earlier age than most children read at present . . . However, there is another point to consider: Learning opportunities cannot be withheld until the time that learning can be undertaken with maximum efficiency. The age of maximum learning speed for most complex academic skills is probably the early twenties, but academic learning cannot be postponed until this time. Most academic learning and most non-academic learning too, must take place at a time when the child is far from having developed to the point of maximum learning efficiency. . . The importance of reading as a key to learning in most other areas requires that the skill be acquired at a relatively early age, even though it might be learned much more rapidly one or two years later."

Myklebust (1954) has shown that the pro-

cess of reading is a complex learning task which requires that the individual integrate non-verbal experience, acquire auditory experience and then acquires a visual verbal system which represent the experience and the auditory symbol.

Johnson and Myklebust (1967, p. 149) point out: "The acquisition of each symbol system requires a number of integrities. It assumes ability to integrate nonverbal experience, that the individual will be able to differentiate one symbol from another, attach meaning to it, and retain it. For example, in acquiring auditory language the child must differentiate the symbol *cat* from the other symbols that he hears; he must associate this particular auditory unit with the animal; next he must store the symbol for future use and be able to recall and say it when communicating with others. Likewise, in learning to read he must be able to discriminate *cat* from other visual symbols, associate with experience, with the auditory symbol, and remember it."

Reading instruction as usually practiced by the schools assumes that reading is based upon some unitary developmental process. No formal educational procedures are required in producing "readiness" and in teaching reading. Since "readiness" comes about as a consequence of some mystical force operating within the organism, all that is required is an encouraging situation in which the child can obtain a meaningful vocabulary from meaningful experience. As may be seen this is an incidental method of learning. Some have, indeed, learned by this method, others in spite of it, and still others not at all.

The last brings sharply into question the nature of readiness and the method of instruction. Such questions are ordinarily stilled by explanations of mental retardation and emotional disturbance. The dyslexic population, however, are neither of these; the dyslexic may be above average in intelligence, emotionally stable and extremely desirous of the ability to read. It is this population which questions the maturationist view and demands some reconsideration of philosophy and education. This is illustrated by a research program with dyslexics.

In the summer of 1967, 105 students were selected for participation in such a research program undertaken by the Reading Disability Center and Clinic of the University of Alabama Medical College in conjunction with the Birmingham University School. The average IQ of the sample as indicated by the Stanford-Binet Form L-M was 111 with a SD of 12.85. All the children were one year or more retarded in reading relative to grade placement. The mean chronological age was 11.13 which indicates a 5.3 grade reading level. They were two or more years retarded relative to reading expectancy, MA=12.3—5 =7.3. The mean obtained on the Gates-McKillop Oral Reading Test at the outset of the program was 4.02 or a 9 year 8 months level. The mean score on the Right-Left Discrimination Test was 25.5 with a SD of 7.12 as compared to a mean of 11.10 with a SD of 10.20 for a "normal" population. All of the subjects fell within a normal range as indicated by the Rorschach. All came from communities where educational facilities were regarded as adequate. All were aware that they had reading problems. The problem had been so diagnosed by school authorities and/or psychologists. All were diagnosed as dyslexic (Shedd, 1961, 1967, 1968). All records are complete for 105 subjects. The age distribution was as follows:

Age	*f*
6	1
7	11
8	9
9	10
10	14
11	15
12	15
13	12
14	11
15	3
16	3
17	1

Information was provided by the parents by way of questionnaire as to immaturity, retention, tutorial help, remedial help, and social promotion. The questions were as follows:

1. Has the child been described as immature? Yes____ No____.
   By whom was the description given.
2. Has the child been retained in a grade or grades? Yes____ No____. What grade(s)?_____.
3. Has the child been "socially" promoted? Yes____ No____.
4. Has the child had tutorial help in language skills (reading, writing, and spelling)? Yes____ No____. Indicate when and for how long.
5. Has the child received special help in the schools? Yes____ No____. Indicate when and for how long_____.

The following is a frequency breakdown of characteristics in terms of all the logical combinations:

Retained	3
Immature	9
Tutorial help	15
Remedial help	0
Retained-immature	10
Retained-tutorial help	4
Retained-remedial help	0
Immature-tutorial help	13
Immature-remedial help	1
Tutorial and remedial help	1
Retained-immature-tutorial help	13
Retained-immature-remedial help	6
Retained-immature-remedial help and tutorial help	16
Immature-tutorial and remedial help	6
Retained-remedial and tutorial help	0
Social promotion	3
Social promotion-immature and tutorial help	1
Social promotion-immature	1
Social promotion-tutorial help	1
No indicated characteristics	2

Of this sample 64 per cent had been diagnosed as immature by the teacher, guidance counselor or other adult. Forty-nine per cent of the total sample had been retained one or more years and 5 per cent had been socially promoted. Thirty-two per cent of the sample had received tutorial help only, 6 per cent had received remedial help only, and 23 per cent had received remedial and tutorial help. A total of 71 per cent had received remedial and/or tutorial help. Thirty-one per cent of those retained received additionally tutorial and/or remedial help. In addition, 17 per cent of the total had received psychiatric counseling. Only 4 per cent had been retained or socially promoted without additional help or diagnosis.

Remediation was not new to this population. They had had warm rapport with tutors. They had been the object of special help by teachers. They had been placed in special remedial programs. They had received psychiatric counseling. For many, everything that could be provided had been provided. Another program was not likely to arouse enthusiasm and lively interest. Should no gains or only small gains be accomplished the program would fare as well as previous attempts at remediation.

A program which related to basic skills or tasks was employed. The method of presentation was geared to the nature of the dysfunction (Shedd, 1968). After eight weeks of concerted effort a retest employing the Gates-McKillop Oral Reading Test indicated a mean of 5.95 grade level, an increase of 1.93 grade levels.

The following is a breakdown of frequency and rate of improvement:

Improvement	*f*
.0— .4	7
.5— .9	25
1.0—1.4	20
1.5—1.9	10
2.0—2.4	9
2.5—2.9	8
3.0—3.4	10
3.5—3.9	7
4.0—4.4	2
4.4—4.9	6

The implications to education are fairly obvious; what time, energy, effort, money, and frustration might have been eliminated by diagnosing the children properly when they first entered school? How much easier it might have been to train the children if unlearning or reorganization had not been required?

The concept of "maturation" or "readiness" as being biologically based is so critical to educational theory and the practice which derives from it that there is little possibility of alteration save a complete revolution. Those who are concerned with the normal educational growth of all children are faced with launching such a revolt or providing alternatives. The latter seems more reasonable and efficient.

The professional group which by dint of training can provide the greatest insight to this problem is that of pediatricians. In most communities they must examine the child to make determinations as to his competency for school. While knowledge for such competency does not ordinarily derive from their previous professional contact with the child, they are best situated to bring a multidimensional view to bear. They could differentiate between behavioral and neurological disorders. They could separate those caused by definite neurological deficit from those that produce behavioral problems because of frustration due to the inability to perform. They could best screen these individuals, relate screening information to clinical history, make necessary referrals for additional evaluation, interpret such information for parents in terms of educational procedures.

Just such an operation has been undertaken by a group of pediatricians in Florida. Working with interested educators and psychologists they have devised screening procedures which may be administered in the pediatrician's office. The results of these devices allow for (1) school referral, or (2) additional diagnostic procedures. The results of the diagnostic tests allow them to make judgments of the type of education which the child requires. Finding educational facilities lacking for some children, they have taken the initiative to see that an adequate tutorial program has been developed.

Learning disabilities are not fads, they arise from individual difference and present incapacity of the educational system to cope with this difference. It would appear that some order might be created if an empirically based concept of mental growth might be employed. Then truly the phrase, "Education is Growth," would have significance to all children.

References

1. Beach, F. A. and J. Joynes 1954. "Effects of Early Experience Upon the Behavior of Animals." Psychological Bulletin, 51, pp. 239-263.

2. Fowler W. 1962. "Congenital Learning in Infancy and Early Childhood," Psychological Bulletin, 59, pp. 116-152.

3. Hebb, D. O. 1949. The Organization of Behavior, John Wiley Sons, New York, pp. 109-118.

4. Hilgard, E. R. 1953. Introduction to Psychology, Harcourt Brace and Co., New York.

5. Johnson, D. J. and Myklebust, H. R. 1967. Learning Disabilities, Greene and Stratton.

6. Melzack, R. 1962. "Effects of Early Perceptual Restriction on Simple Visual Discrimination." Science 137, pp. 978-979.

7. Money, J. J., G. Hampson and J. L. Hampson 1957. Quoted by Scott.

8. Myklebust, H. R. 1954. Auditory Disorders in Children, a manual for differential diagnosis,

New York, Greene and Stratton.

9. Passmanick B. and P. H. Knoblock 1960. "Epidemiologic Studies on the Complications of Pregnancy and the Birth Process which may Have Implications for The Prevention of Mental Disorders in Childhood." Paper presented to International Preparatory Commission of The International Association for Child Psychology, Feb. 7-12. Cambridge, Mass.

10. Ruch, F. L. 1958. Psychology and Life, Scott Foresman and Co., Chicago. pp. 44.

11. Scott, J. P. 1965. "Critical Periods in Behavioral Development" in Readings in Animal Behavior. (T. E. McGill ed.) Holt Rinehart and Winston, pp. 271-286.

12. Shedd, C. L. 1961. The Diagnosis and Treatment of Symbolic Confusion, In Changing Concepts of Reading. Instruction (J. A. Fegural ed.) International Reading Association Conference Proceedings 6: 97-102.

13. Shedd, C. L. 1967. "Some Characteristics of a Specific Perceptual-Motor Disability—Dyslexia. The Journal of Med. Association of The State of Alabama. 37: 150-162.

14. Shedd, C. L. 1968. "Clinical Management of Dyslexia." J. of Learning Disorders.

15. Sorenson, N. 1954. Psychology in Education, McGraw Hill, New York, pp. 260-261.

16. Travers, R. M. W. 1967. Essentials of Learning. MacMillan Company, New York. pp. 280-281.

17. Walk, R. D. and E. J. Gibson, H. L. Peck and T. J. Tighe 1959. "The Effectiveness of Prolonged Exposure to Cutouts V C Painted Patterns for Facilitation of Discrimination." Journal of Comparative and Physocological Psychology, 52, pp. 519-552.

The Meal Ticket Syndrome

Henry Spira, M. D., F. A. P. A.

Birmingham, Alabama

Meal Ticket: 1. A ticket or card bought for a specified price and redeemable at a restaurant for food. 2. U. S. slang. One who, or that which, provides a livelihood for another. (Funk and Wagnalls Standard College Dictionary).

Psychoneuroses result from conflicts the sources of which are largely inaccessible to conscious recognition. These conflicts often consist of a clash between the "autocracy of conscience" and the "anarchy of impulse" (Erikson). Unconscious resentment over real or imagined exploitation by one's family may give rise to a psychoneurosis which has been—somewhat flippantly—termed a meal ticket syndrome. Unable to reconcile this resentment with his sense of obligation to his family, the patient finds a pseudo-solution in neurotic illness. His aim, though unrecognized and unacknowledged, is often only too well accomplished: namely, his ability to earn a living is impaired. A brief discussion will show some of the personality aspects and some facets of the social pressures which combine to produce this type of emotional illness.

That the man should be the breadwinner for his family, is a basic demand of society which is, and should be, internalized as part of the male superego, the unconscious part of the conscience. Exploitation, of course, is a different matter. The sociologist may speculate as to the sources of such exploitation. The mate may have an unhealthy preoccupation with material goals, or may overvalue social prestige. An excessive drive for permanent security may impose upon the husband a heavy work and insurance load. Perhaps there may be resentment in the breadwinner over the relative easing of female responsibilities in the household and rearing of children, which in the past led to a more equal work load. Job frustrations are not always appreciated by the wife. In recent years, male patients often complain that they are the head of the household in name only, and no longer control financial and other decisions, which fact provided compensatory satisfactions for their fathers and grandfathers. Nor should it be assumed, of course, that only the male develops the meal ticket syndrome. Many women are found to suffer of this type of neurosis. Nurses, for example, are for several reasons often victims of a dependent and demanding husband or family. Furthermore, it is not always the marriage partner who causes this type of situational stress; a parent, a sibling, or others may be the ones who take undue advantage of the patient.

Certain personality types are more apt to develop the meal ticket syndrome. Compulsive, conscientious persons, with a strict upbringing, excessive guilt feelings, and a strong awareness of their social duties, readily succumb to this conflict. It should be noted that the exploitation may be fancied rather than real. The patient may be paranoid, or he may harbor unconscious hostility toward the opposite sex in general, due to unfavorable early life experiences with his parents or members of the opposite sex. Parental models are important. One may see a lack of willingness to undertake ordinary responsibilities in a man whose father similarly abandoned his duties to the family at an early age. The patient himself may have an excessive drive toward material success, which in a defensive manner he imputes to his wife. To the patient, however, the exploitation is real, even when this belief is based upon false premises.

The nature of his reaction patterns will depend upon the patient's personality structure and the degree to which he is consciously aware of his problem. He may have an abnormal need to suffer, and for this reason, acquiesce to excessive demands of his environment. Others accept a situation of this type because of guilt feelings over their sexual or other inadequacies. At the other extreme, the person may well become aggressive in various ways. He may quit his job, though he is consciously aware that this will place a severe stress upon his family; he may compensate by infidelity, or escape from the situation by desertion or divorce. Needless to say, when mature people are involved who are able to discuss their problems and to arrive at a compromise, this syndrome will not develop. Particularly when the patient is not consciously aware of the problem; when he is unable to resolve the conflict between his impulses and resentments versus his conscience and feelings of obligation; or when positive and negative feelings toward the family co-exist, this conflict engenders anxiety expressed as neurotic symptoms. It has been mentioned that the secondary gain, as it is called, of such a neurosis is frequently considerable in that the neurosis disables the person vocationally, thereby striking directly at the source of what he considers unfair treatment by his family.

The following fragments of case histories illustrate some of the above statements.

A middle-aged business man who has a socially ambitious wife and children suffers a minor head injury and subsequently develops vague frontal headaches which become continuous, do not respond to any kind of treatment, and eventually necessitate retirement from his important position.

A middle-aged male represses his anger over his wife's domineering attitude and her frequent requests for financial aid to her parents. Whenever pressures mount, he withdraws into excessive alcohol and drug intake.

A worker becomes totally disabled through functional gastrointestinal symptoms. He feels that he has been unduly exploited by a relative whom he had promised his parents to support after their death.

After his father deserts the family, a young man of 19 has to support his mother and sister. He loses his job and searches for another without success. Suddenly the right lower extremity becomes rigid, and he cannot flex the leg upon the thigh. This puts an end to his efforts to obtain employment. Under sodium amytal, he expresses his resentment over having to work for his mother and sister, a resentment of which he was previously unaware and which contradicts the voice of his conscience. Normal function returns shortly with suggestive psychotherapy.

A man with overwhelming obligations for the support of a large family becomes amnesic for his past life, moves to another city, changes his name, and remains oblivious to his former existence.

As can be seen, the meal ticket syndrome can take the form of post-traumatic neuroses, addictions to alcohol and drugs, various somatizations, depression, conversion reactions, and dissociative reactions. In dissociative reactions, the patient's forgetting of the past and occasional flight not only from his responsibilities, but from the place where he had to fulfill these responsibilities, show very clearly how he escapes from an intolerable reality under the protective mechanism of saying that he is not really committing this heinous deed. He is not himself, he "says" unconsciously, but another person, whom he unconsciously impersonates. In w o m e n , escape into hypochondriasis, neurasthenia, dependence, and invalidism is often seen; in other words, they usually respond in a more passive manner.

The physician can occasionally prevent the development of this type of neurosis if he is acquainted with the patient's life situation. Because of their marked sense of social re-

sponsibility and the frequency of compulsive personality characteristics occurring among them, physicans themselves may be in danger of developing such a syndrome. In regard to treatment, recognition of the nature of the problem is the first prerequisite. Counseling with the family and manipulation of the patient's environment through the physician's authority are often helpful when there are realistic grounds for the patient's conviction that relatives treat him in selfish ways. In psychotherapy, one will strive to bring the elements of the conflict into the patient's consciousness and to guide him toward more mature handling of this conflict. His relationship with his parents, the way his father took care of his own responsibilities, the patient's experiences with the opposite sex and his attitude toward the opposite sex, his emotional needs and feelings of guilt deserve discussion. Whether he is justified or not in his contention that his environment is taking advantage of him, the patient's entire personality may require exploration and reeducation so that he can deal with his life situation in more mature ways.

Normal And Abnormal Behavior From Learning

Wallace Marshall, M. D.

Montgomery, Alabama

No serious abyss seems to exist between normal and abnormal behavior.[1] Learning brings environmental stimuli to the recipient cortical centers of the brain where certain neurochemical changes occur. These can produce either normal or abnormal behavior, depending upon the size of the incoming encoding stimuli and the nature of the recording cortical centers which receive these perceptual stimuli (engramming process).

In this communication some of the many recent findings will be reviewed which concern these cortical changes from learning. Further, I shall attempt to explain how these events may produce either normal or abnormal behavior which arise from the learning processes.

It may be well to remember the principles which have to do with theory formation described in a previous article.[2] It has not been necessary to use Freudian mechanisms to explain those processes which are concerned with cerebration. Rather, the approach will be a biologic one as we consider normal and abnormal behavior and how a state of flux exists between them. It is the learning process which plays the dominant role for studying cerebration and behavior; if an individual cannot learn for any reason, he will have amentia.

The recent output of scientific data on learning and the resultant cortical cell changes (encoding) these produce are extensive. Hence, it is only possible to give our readers a partial kaleidoscopic view of these findings. The psychoallergic approach to behavioral patterns will be understood better if cortical changes from learning are appreciated, remembered, and then utilized by the reader.

The importance of prenatal sensory stimuli is now being recognized. Dubois[3] mentions that while still in their eggs, chicks are conditioned to some auditory and visual stimuli. After these chicks are hatched, they show different responses to these same stimuli, while unconditioned chicks do not show such changes. Dubois writes about the influences which memory and heredity exert upon the individual. These influences produce permanent traces or imprints which he calls engrams. This is but another way of stating that learning affects the recipient cortical cells by producing the ability to use memory. The exact nature or the makeup of these cortical cells have been imprinted previously through the individual's heredity factors, although by exactly what manner is unknown presently.

Neonatal influences from pressures (touch) and possibly sound within the mother's uterus appear to play important roles toward the behavior of the born individual. Probably an example will help to clarify this point. From birth, my German Shepherd puppy, who was the runt of the litter, insisted upon sleeping on his back with his paws flexed on his abdomen. This behavior baffled me until I recalled that some canine fetuses lie upside down and in the bottom position in the bitch's uterus. There the unborn pups receive pressure stimuli from the mother's uterine walls. After birth, these pups reassume their prenatal positions which might possibly add to the well-being sensations derived from such a prenatal position. This identical behavior has been studied in human infants with respect to their positions during sleep following birth. Hence, prenatal learning produced engrams in those

cortical cells which perceived such pressure stimuli prenatally. Prenatal learning thus influences the born individual to assume his former uterine position during his sleep intervals. This field of behavior is being studied in order to determine other possible intrauterine factors which may influence the individual's postnatal behavior.

Schmitt[4] wrote that the brain's cortex probably contains ten thousand million neurones (nerve cells) and possibly ten times that many glial cells. Many of these nerve cells receive other neuronal connections which may number in the thousands. These connections are called synapses. The microscope is unable to deal satisfactorily with these myriads of neuronal nets. Possibly only a few per cent of these networks have been identified in the brain's cortex. Schmitt wrote that learning, memory and the other higher brain functions are believed to have resulted from neuronal impulses which transversed these nerve networks. He calls attention to those hereditary DNA-RNA protein systems which have provided such molecular cues. These chemical changes thus can produce rejection when an organ from one individual is grafted to another because of the individual's molecular detection system which recognizes the foreign organ which was grafted to the individual. In other words, this molecular detection system can recognize like from unlike, and it appears to operate by the use of the larger molecules or by an "ordered assembly of smaller molecules." However, the larger molecules code an almost infinite number of variables in the form of a small alphabet. The polysaccharides and the fat-like lipids probably transfer information. Genetic and immunologic memory occur only in the nucleic acids DNA and RNA.

The engramming or the coding of molecules in these cortical receptive cells arises from incoming sensory stimuli. Some workers have termed this process one of the current "library" theories since the results from engramming are stored in these sensitized cortical cells. They are sensitized because they are then capable of recognizing similar newly introduced sensory stimuli which travel to these engram or coded centers. Thus, the term of "library" theory seems to be most appropriate (to use a shop-worn psychiatric term) because such learned information is stored in these centers similar to a library. The theory of Psychoallergy can be considered also as a library theory.

The chemical nature of such engram changes in these cortical cells after learning has taken place appears to offer much in discovering the exact mechanisms which may be involved with such processes. Among the leaders in this field is Hyden[5] who found that animals, who were taught to balance on a wire to get food or to change handedness, produced changes in the ratios of purine and pyrimidine bases of RNA in neurones concerned wtih this process.

Bresler and Bitterman[6] used tissue taken from fish embryos during gastrulation and used proposed tectal sites to transplant it in similar embryos. Upon maturity, these fish were trained in habit reversals. Prospective improvement occurred in two of six animals taught reversals, which is not typically found in fish but is observed in higher animals. Two fish showed unusually few mistakes while the other two behaved normally. These behavioral differences were correlated with brain structure differences. With the above experiments, apparently the learning processes produced behavioral changes not found in the controls.

Mandell and Spooner[7] discussed various research approaches to the chemistry of the "mind." They found these to be promising but difficult to interpret.

McConnell[8] mentioned Hyden's RNA theory for memory. McConnell thought that the cell involved with memory storage in planaria was the neoblast which can migrate anywhere in the animal's body and also has the power for regeneration. So when the animal is bisected, the missing parts are regenerated by neoblasts which are rich in

RNA and the engrams which cause memory formation.

Note the difference in McConnell's approach to that of this author who explains memory formation on possible antibody production produced by learning (psychoallergic theory).

Agranoff's excellent review of Hyden's recent volume[9] points out Hyden's conclusion that RNA can pass from glia to neurone, and that changes in the amounts of RNA can take place with learning, among other influences.

Agranoff[10] has run a series of experiments which dealt with learning and memory in goldfish. He taught goldfish to perform simple tasks and then injected a substance which blocked protein synthesis in the skull. These animals forgot what they were taught. Agranoff mentioned the possibility of marking chemically each nerve cell through such learning processes (engramming).

Immunologic Learning

Bogoch[11] calls attention to the immunological system which apparently can recognize a learned response from others. He mentions the possibility for the formation of antibodies from learning, which the theory of psychoallergy features. Bogoch mentions the argument propounded by some investigators that the transfer of information (engrams) is stimulus—specific.[12] He suggests a close association between immunological problems and those to be found in theories involving nucleic acids and memory.[13] Perhaps the engram-involving memory is encoded in macromolecules involving protein.[14] Our readers are urged to read Bogoch's monumental work.[11]

Bogoch[15] views those synthetized proteins from the learning processes as being possibly analagous to the structure and function of antibodies. Both the memory and immune mechanisms appear to have a number of points of comparison. Bogoch prefers the term of "anamnestic response" for these biologic reactions.

We shall have to wait until the immunologists evolve some necessarily specific procedures for determining whether or not the learning processes are capable of forming specific antibodies. This may well be the key for unlocking the knowledge long awaited for these processes which have to do with learning and its related phenomena.

The foregoing references regarding those neurophysiologic changes which occur with learning have not negated our theory for learning. Encoding of the brain cells, receiving incoming neural stimuli, occurs with the storage of this information from one's environment. Although the precise chemical changes are not known presently, the fact remains that these sensitized cortical cells have learned from such sensitizations. This change, which can be regarded as knowledge, stores these sensitized cell changes in the brain cells until associated incoming neural perceptions are recognized by these encoded neural structures when the psychologic process of recognition takes place.

Overlearning or the hypersensitization of these cortical structures may occur depending upon the amount or the dosage of these new incoming stimuli. As has been stated previously, abnormal behavior reactions may thus ensue because of a surmenage or overflow of reactions and thus produce such overlearning. This leads us to the consideration of the author's analogy involving the

Leyden Jar Principle

This is the author's method for explaining the "library theory" for the storage of information in the cerebral cells. Some forms of electrical energy are stored in the Leyden jar and also in the cortical cells; the latter results from learning, while the former originates from the genesis of static electricity.

The Leyden jar is a fascinating piece of electrical equipment which is studied usually during the introductory course in physics. This jar consists of glass which has about 2/3 of its lower surface covered with tin foil or some type of conducting surface. It has a

knobbed conductor which connects with both the inside and the outside surfaces of the jar and allows static electricity to become stored. It was discovered at the University of Leyden in 1745 by Musschenbroeck who named it after that school.

When the charged Leyden jar is touched it discharges an observable shaft of electricity. Especially during cold weather and upon movement the human body can act also as a Leyden jar; by rubbing one's feet on a thick rug enough static electricity can be generated so that a snapping shock may occur as the individual touches a grounded metal object.

Through the use of the Leyden jar principle we can infer that knowledge in the form of stored energy (encoding) may operate similarly, for the stored potentials may be able to recognize and react to other similar encoding which originates from environmental psychoallergens through perception. Such reactions may be either within normal or abnormal limits, depending upon the caliber and length of time of the encoding reactions. A minimum encoding process may lead to learning reinforcement, which can be likened to the further storage of increased potential in the Leyden jar. The Leyden jar reaction may produce a massive discharge of potential or a surmenage of energy into the individual's cerebral exists through either the autonomic, the motor systems, or both. The observable behavior of the individual will show the caliber of the ensuing release of energy from the affected encoded cortical cells which act similarly to the discharging Leyden jar.

These discharges of potential can produce two separate forms of behavior. The *histic* form has already been mentioned through motor action which produces some form of muscular movement or through the autonomic nervous system which produces sweating, blanching of the skin, and other forms of autonomic behavior.

The other type of behavior is the *nousic* form[16] which describes the type of behavior which occurs with cerebration, memory recall, or associated forms of behavior, such as problem-solving or from the conscious use of the sensoria.

Clinical examples of histic and nousic cortical discharges

(a) Nousic. One of the most common effects which results from electroconvulsive therapy (ECT) is the loss of recent memory. Memory itself may have been produced by a charging or encoding process within the cortical cells. Recall allows this stored energy to become released and utilized by the individual. However, when electrically induced convulsions or when convulsions are produced by other agents such as halothane or other drugs, these stored cellular potentials may become rearranged, and the subject at least temporarily loses his memory. This is the author's suggestion for explaining ECT's results and other forms for convulsive therapy, which can be added to the 50 or more theories which deal with this phenomenon. This is an example of a normal nousic reaction which is related to cerebration.

A common example of a nousic reaction occurs with the deja phenomena, where an individual feels that he has perceived or heard something before (deja entendue). Or he may believe he has carried out some act he has never engaged in previously (deja eprouve). He may think what is now happening occurred previously (deja fait). He may feel that he has experienced the same present thoughts previously (deja pense). He may also feel that some forgotten experience has been related to himself by other persons (deja reconte). He may suffer the delusion that a new experience has been experienced previously (deja vecu). If he feels that he has had the same desires previously this is deja voulu. If he suffers the delusion that a new experience is viewed incorrectly as a repetition of a previous experience, this is deja vu.

All of these clinical examples of the deja phenomena can be related to the improper

intrepretation of memory recalls or discharges which may be based on a marked similarity of present psychoallergens to those which have already produced memory storage. Illusions and delusions seem to be related closely. These nousic reactions delude the individual because of a similarity of the psychoallergens which formed memory and the current psychoallergens which presently bombard his perceptive cortical areas (encoding process). These are only a few examples of nousic reactions.

(b) histic. A few such examples occur with any autonomic action or glandular function such as sweating, blushing, crying, etc. Muscular responses are also usually histic in type.

(c) mixed reactions—histic and nousic. Examples are the nousic manifestations of epilepsy which produce aurae, etc., while histic manifestations of epilepsy are demonstrated by frothing of the mouth and convulsions, etc. Such mixed reactions, (nousic and histic) can occur with hypnosis where an arm can be temporarily paralyzed (histic reaction) or the hypnotized subject can be made to forget some well known subject (nousic reaction). Also, the post trance state can be made to exhibit mixed reactions, such as recalling a forgotten name or situation (nousic reaction), performing with some muscular motion, such as walking with a limp (histic form of reaction), or by performing a post-hypnotic suggestion, such as yawning or nodding one's head.

Therapeutically, the psychoallergic theory can be employed to desensitize various complexes (states of hypersensitivity) in individuals, which was mentioned in a former article.[17] A good example of this was offered by a friend[18] during a recent discussion of psychoallergy. Some individuals have been hypersensitized to certain religious teachings which they could not intellectually accept. The result was their refusal to partake in further functions within their church. During our discussion, it was suggested that such individuals are drawn to a religious group which allows them complete freedom concerning their religious convictions. In other words, the group can worship as they wish, and hence, they are protected against further obnoxious psychoallergens which had caused hypersensitizations to their erstwhile religious participation. The process resembles a rest cure and may well be a bit similar to those principles as practiced with Christian Science where prayers are presumed to overcome various diseases (mental catharsis).

Neurotic and Psychotic Behavior

The degrees of hypersensitivity which can be produced from engramming (overlearning) depends upon the nature of the cerebral recording centers and the caliber of the incoming perceptory stimuli . . . Among those factors which can influence this physiology is the nature of the cortical cells which are influenced through heredity. The fact that certain cells possess the propensity for unusual learning (excessive encoding) can occur with those individuals who develop unusual learning skills, exemplified by musical genii or prodigies in chess or mathematics, etc. Perhaps such states can be regarded as borderline in nature, that is, between the normal and the abnormal.

Thus, the amount of learning and perhaps overlearning will determine the degree of hypersensitivity of these cortical recording (encoding) centers. An excessive amount of further related psychoallergens (overlearning) may produce abnormal behavior in the forms of neurotic or psychotic behavior, although space will not allow for such a discussion at this time.

A Concept of Schizophrenia

The literature abounds with articles which deal with this disorder. All sorts of etiologies and theories have been suggested. Yet, schizophrenia continues to be the most favored topic in psychiatry because it is so bizarre in nature, and it costs more in money and suffering than any other disease.[19] This disorder has been discussed recently by Braceland,[20] Hans Kind,[21] whose articles con-

tain interesting comments by other psychiatrists, and by Kraines[22] who introduces a fascinating original theory.

Of the many schizophrenic symptoms, perhaps the one which puzzles scientists the most is the unpredictability of these patients. They can suddenly change their behavior without warning for they may appear quite calm, but the next moment they may become very boistrous and even manic.

Without belaboring the many symptoms of schizophrenia, perhaps one can now understand why these patients are so uninhibited emotionally. Their markedly hypersensitized cortical cells may discharge at random (Leyden jar phenomenon) and thus produce a surmenage of nerve impulses from these supercharged cortical cells to the motor or the autonomic systems or to both of these components. However, the trigger mechanism for these excessive discharges is not known presently. The variability of such psychotic behavior seems to coincide with the degree of hypersensitivity and the psychoallergic theory.

A state of flux apparently exists between normal and abnormal behavior as well as between those theories which attempt to explain such phenomena. A biologic approach to these problems does not further overload such studies with additional vague nomenclature which is foreign to the various biologic fields which include the neurosciences and psychiatry as further studies of behavior are contemplated.

References

1. Marshall, W.: Theory, Learning and Origin of Complexes. 38:916-921 (Apr.), 1969. Journal, Medical Association of Alabama.

2. Ibid.

3. Dubois, R.: So Human an Animal. Charles Scribner, N. Y., 1968, p. 89.

4. Schmitt, F. O.: Molecules and Memory. The Harvard Review Vol. III (3), Spring, 1965.

5. Hyden, H.: Biochemical Changes Accompanying Learning, in Quarton, G. C. et al. (Eds.): The Neurosciences—A Study Program, Rockefeller University Press., N. Y., to be published. (quoted by Schmitt, F. O.: Molecular biology among the neurosciences. Arch.-Neurology 17:561 (Dec.), 1967.

6. Bresler, D. and Bitterman, M.: Learning in Fish with Transplanted Brain Tissue. Science 163:590 (Feb. 7), 1969.

7. Mandell, A. J. and Spooner, C. E.: Psychochemical research studies in man. Science 162:1442 (Dec. 27), 1968.

8. McConnell, J. V. in Corming, W. C. and Balaban, W.: The Mind: Biological approaches to Its Functions. Inter-Science Publishers, Division of John Wiley and Sons, N. Y., 1968. P. 55.

9. Agranoff, B.: Closeups of the nervous system. Science 163:268, (Jan. 17), 1969. Agranoff reviews Hyden, H.: the Neuron, Elsivier, N. Y., 1967.

10. Agranoff, B.: Memory and Protein synthesis. Scientific American, June, 1967, p. 115.

11. Bogoch, S.: Biochemistry of Memory. Oxford Univ. Press, N. Y., 1968, p. 13.

12. Bogoch, S.: Vide Supra (11), p. 72.

13. Bogoch, L.: Vide Supra (11), p. 88.

14. Bogoch, L.: Vide Supra (11), p. 121.

15. Bogoch, S.: Personal communication.

16. Dorland's Medical Dictionary. W. B. Saunders Co., Phila. 24th Ed. 1965 p. 1023. This term "nousic" was coined by the author, circa 1937. It originates from the Greek "nouos" meaning mind. The term refers to the functioning of the intellect or to cerebration in contrast to the word "histic" which refers to the functioning of a cell, tissue or an organ of the body. As an example, a histic reaction occurs when a cell or cells discharge an enzyme, or when a muscle contracts or an individual screams. A nousic reaction occurs when one thinks or reasons.

17. Marshall, W.: Learning and The Development of Frustrations. Journal of the Medical Association of Alabama 38:422 (Jan.), 1969.

18. Delahay, Merriam: Personal communication.

19. Grinker, R. R.: An essay on schizophrenia and science. Arch. Gen. Psychiat. 20: 7 (Jan.), 1969.

20. Braceland, F. J. Med. World News, Jan. 22, 1968, P. 156.

21. Kind, H.: The psychogenesis of schizophrenia. Internat. J. psychiat. 3:353 (May) 1967.

22. Kraines, S. H.: Schizophrenic physiopathology. Psychosomatics. 9:19 (Jan.-Feb.), 1968.

nursing care for cancer patients–

...a major concern for their families, *and* for their physicians. In a unique pioneering service, the American Cancer Society is deeply involved in finding a solution.

Recognizing the phenomenal growth of nursing homes—aware of the shortage of nurses—knowing the implications of the extended care benefits of Medicare—the Society has launched a dramatic educational demonstration project on cancer nursing for nursing home staff. Special emphasis is on colostomy irrigation, care of the laryngectomized patient, care of an ileal bladder, and emergency nursing. To achieve maximum application of this plan, a cadre of nurses is being trained by the Society to conduct cancer nursing courses in nursing homes throughout the nation.

This endeavor has been warmly endorsed by the American Nurses Association and other professional organizations. We feel sure that such a program, bringing skilled nursing care to the bedside of the cancer patient, will be enthusiastically received by the medical profession.

AMERICAN CANCER SOCIETY®



THIS SPACE CONTRIBUTED BY THE PUBLISHER

AMERICAN CANCER SOCIETY ALABAMA DIVISION, INC.
1025 SOUTH 18th STREET
BIRMINGHAM, ALABAMA 35205



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

NOW IS THE TIME... TO GIVE HER TIME WITH OVULEN-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.



The new mother needs time . . .
to adjust to motherhood,
to give her new baby all the love
and attention he requires.
She needs time for her husband . . .
and for herself as well . . .
so that she can come to terms
with the increased cares
and responsibilities now facing her.
She needs time to decide
when she will have additional children
and how many she will have.

OVULEN-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

GIVES HER TIME

Your prescription for Ovulen-21 gives the new mother time to meet her family's present needs...to plan for her family's future.

She can take Ovulen-21 confidently and comfortably month after month. Its dependability is enhanced by its simplicity of use. A woman needs little or no time to learn the simple Ovulen-21 regimen: three weeks on—one week off. And the automatic record-keeping of the petite, virtually "patient-proof" Ovulen-21 Compack® helps to maintain her schedule...helps put time on her side.

Immediately post partum is the time

It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

It is also the most opportune time, since she is conveniently present in the hospital, for her to be given both instructions and a prescription.

Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thrombaembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genitol bleeding.

Warnings—Watch for the earliest manifestations of thrombatic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestagen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching. The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.



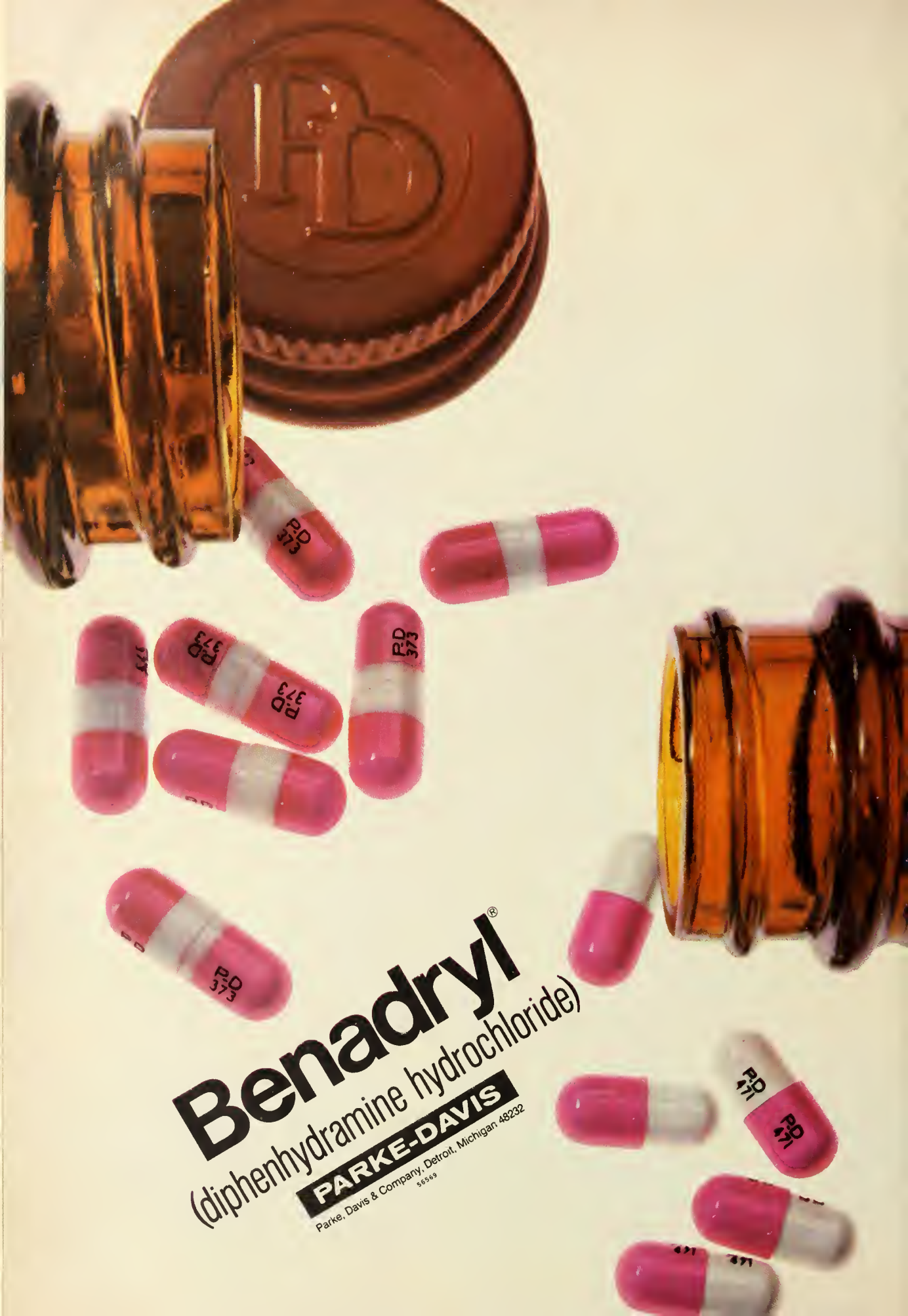
References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see complete prescribing information.

Where "The Pill" Began

G. D. SEARLE & CO., P.O. Box 5110, Chicago, Ill. 60680 SEARLE

972


Benadryl®
(diphenhydramine hydrochloride)
PARKE-DAVIS
Parke, Davis & Company, Detroit, Michigan 48232
55569

Alabama Department of Public Health

Manpower Shortage No. 1 Health-Planning Challenge

By Joyce T. Murphree

Since organizing little more than a year ago, members of the Alabama Advisory Council for Comprehensive Health Planning have plunged with gusto into a variety of health problems besieging Alabama. Recommendations have been made to the responsible agencies in several areas of health care.

The advisory council was established under terms of Public Law 89-749 as a means of coordinating health programs on the local level. The council studies health needs and sets priorities.

Foremost on the council's priority list is the shortage of health manpower. This includes physicians, dentists, and nurses, as well as the allied health professions.

Other priorities set by the council are: (2) education of professional and subprofessional health workers; (3) Medicaid; (4) air pollution; (5) water supplies and sewage development; (6) solid waste disposal; (7) regional medical centers; (8) emergency ambulance service.

At its April meeting the council recommended the establishment of six additional regional medical centers in Alabama. Based on recommendations of the Booz, Allen, Hamilton Report, the council further advised that medical schools be developed in conjunction with three of the regional centers.

The council set as goals the establishment of all six regional medical centers by 1970 and the expansion of medical schools to two in 1970, three in 1974, and four in 1989. Sites for the medical schools have not been suggested by the council, but discussion generally centers around those cities recommended in the Booz, Allen, Hamilton Report—Tuscaloosa, Mobile, and Huntsville in addition to the existing facility at Birmingham.

Regional medical centers would be a part of the medical school facilities, and in addition, regional centers have been proposed for Dothan, Gadsden, and Montgomery. A regional medical center is defined as a general hospital with specialized medical services and an intern program.

Actions taken by the council include:

—Recommended adoption of the Booz, Allen, Hamilton Report as a guide and plan for professional medical education in the state.

—Recognized the Joint Commission for Planning of the Alabama Nurses Association and of the Alabama League for Nursing as the principal planning body for the nursing profession.

—Urged legislation requiring licensing of ambulance drivers and attendants.

—Recommended the passage of legislation to eliminate profiteering from multiple health insurance coverage.

—Supported the need for programs for patients with terminal kidney disease, artifical kidney and transplants. The first need chronologically would be to establish firmly one training/research/demonstration unit.

—Urged the passage of red meat and poul-

try products inspection legislation by the state and designation of the health department as the administrative agency for meat inspection services.

—Recommended careful study before establishing more than one home health agency in the same area.

—Requested the State Planning and Industrial Development Board to include the Alabama Department of Public Health in the initial phases of planning for public water supplies.

—Urged legislation authorizing county governments to operate solid waste disposal systems.

—Urged state legislation to provide additional support for air pollution control measures in Alabama.

—Supported adequately financed outpatient care of tuberculosis patients in all geographic areas of the state. This would allow a reduction in tuberculosis hospital beds to 900 (in the seven district hospitals) from the existing 1125.

—Urged establishment of a ward for recalcitrant tuberculosis patients.

Areawide comprehensive health planning agencies have been established in Jefferson and Mobile counties. These have essentially the same function as the state council in planning for public and private health services for their areas. The Office for Planning of the Alabama Department of Public Health coordinates area plans with overall state plans. Ideally, all parts of the state should be represented by an areawide planning agency and each organizational unit should be composed of more than one county.

BUREAU OF VITAL STATISTICS
PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA

Ralph W. Roberts, M. S., Director

MARCH 1969

Live Births Deaths Causes of Death	Number Recorded During March 1969			Rates* (Annual Basis)		
	Total	White	Non-White	1969	1968	1967
Live Births	5,154	3,499	1,655	16.6	15.9	16.7
Deaths	2,932	2,035	897	9.5	9.4	8.5
Fetal Deaths	84	52	32	16.0	24.3	19.4
Infant Deaths						
under one month	71	46	25	13.8	19.8	16.7
under one year	130	73	57	25.2	31.7	26.7
Maternal Deaths	1	.....	1	1.9	6.0	7.6
Causes of Death						
Bacillary dysentery, amebiasis, 004, 006	.....	.....	.....	.....	.....	.....
Enteritis, other diarrheal diseases, 008, 009	11	7	4	3.6	†	†
Tuberculosis, all forms, 010-019	25	15	10	8.1	8.5	7.9
Diphtheria, 032	.....	.....	.....	.....	.....	.....
Whooping Cough, 033	.....	.....	.....	.....	.....	.....
Meningococcal infections, 036	3	1	2	.....	1.0	1.3
Poliomyelitis, (acute), 040-043**	.....	.....	.....	.....	.....	.....
Measles, 055	.....	.....	.....	.....	.....	.....
Syphilis, 090-097	.....	.....	.....	.....	1.3	0.7
Malignant Neoplasms, 140-209	385	283	102	124.3	126.4	121.0
Diabetes Mellitus, 250	54	40	14	17.4	17.0	17.8
Major cardiovascular diseases, 390-448	1,459	1,056	403	471.2	†	†
Diseases of heart, 390-398, 402, 404, 410-429	961	733	228	310.4	314.5	298.7
Rheumatic fever & heart, 390-398	9	8	1	2.9	†	†
Hypertensive heart & renal diseases, 402, 404	30	16	14	9.7	†	†
Ischemic heart disease, 410-414	836	648	188	270.0	†	†
Cerebrovascular disease, 430-438	392	258	134	126.6	137.6	108.7
Diseases of the arteries, 440-448	87	56	31	28.1	21.9	17.8
Influenza, 470-474	15	9	6	4.8	3.6	0.7
Pneumonia, 480-486	95	58	37	30.7	26.5	23.8
Bronchitis, emphysema, asthma, 490-493	39	33	6	12.6	†	†
Appendicitis, 540-543	2	2	.....	0.6	1.0	0.3
Hernia, intestinal obstr., 550 553, 560	7	4	3	2.3	4.6	3.0
Cirrhosis of liver, 571	15	12	3	4.8	10.5	6.9
Complications of preg., childbirth, 630-678	1	.....	1	1.9	6.0	7.6
Congenital anomalies, 740-759	28	18	10	5.4	5.6	5.4
Immaturity, 777	19	14	5	3.7	6.2	5.8
Accidents, total, 800-949	210	137	73	67.8	65.2	61.5
Motor Vehicle accidents, 810-823, 940	108	83	25	34.9	31.1	32.4
All other defined causes	368	248	120	118.9	118.3	115.7
Symptoms & ill-defined, 780-796	196	98	98	63.3	56.3	43.0

BUREAU OF PREVENTABLE DISEASES

Frederick S. Wolf, M. D., Acting Director

Current Morbidity Statistics

1969

	April	May	*E.E. May
Tuberculosis	93	148	130
Syphilis	54	50	134
Gonorrhea	476	481	336
Chancroid	0	2	1
Typhoid fever	0	0	0
Salmonella	8	34	8
Undulant fever	0	0	0
Shigella	2	13	5
Amebic dysentery	0	0	3
Scarlet fever & strep. throat	453	475	77
Diphtheria	0	1	0
Whooping cough	0	1	5
Meningitis	6	6	6
Tularemia	0	0	0
Tetanus	0	0	1
Poliomyelitis	0	0	0
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	0	1	292
German measles	17	6	11
Chickenpox	56	25	79
Mumps	27	6	77
Infectious hepatitis	53	36	44
Typhus fever	0	0	0
Malaria	0	1	0
Cancer	690	538	728
Pellagra	0	0	0
Rheumatic fever	16	12	18
Rheumatic heart	17	18	26
Influenza	733	164	82
Pneumonia	450	370	277
Rabies—Human cases	0	0	0
Pos. animal heads	9	6	0

As reported by physicians and including deaths not reported as cases.

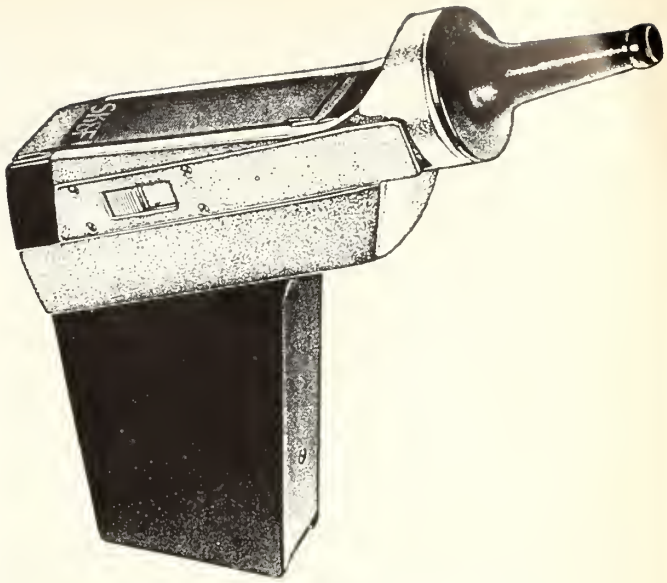
*E. E.—The estimated expectancy represents the median incidence of the past nine years.

---

*Rates: Births and deaths—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

**Does not include late effects

†The Eighth Revision of ICD (New Revised Code) is used beginning with January 1969. Comparison with statistics compiled under the former Code (Seventh Revision ICD) and rates cannot be made. Direct to the Alabama Bureau of Vital Statistics any question about comparability of statistics compiled and rates under the new vs. the former ICD.



See more, do more with the new Hotchkiss™ Otoscope

A revolutionary new instrument rather than an improvement over existing equipment, the Hotchkiss Otoscope employs the principles of modern optics to give you a brighter, clearer, more informative view of the ear canal and tympanic membrane. It's also more versatile than ordinary otoscopes—you can use it for diagnostic or operative procedures without making any changes. Yet the five-ounce Hotchkiss is lighter, easier to handle and carry, and every bit as durable as instruments that offer you less.

See for yourself. Clip and mail the coupon, and our Representative will call for an appointment to show you the new Hotchkiss Otoscope in your office.

SK&F Smith Kline & French Laboratories

Smith Kline & French Laboratories E-30 B
1500 Spring Garden Street
Philadelphia, Pa. 19101

I would like your Representative to call for an appointment to show me the new Hotchkiss Otoscope.

Name _____ Phone _____

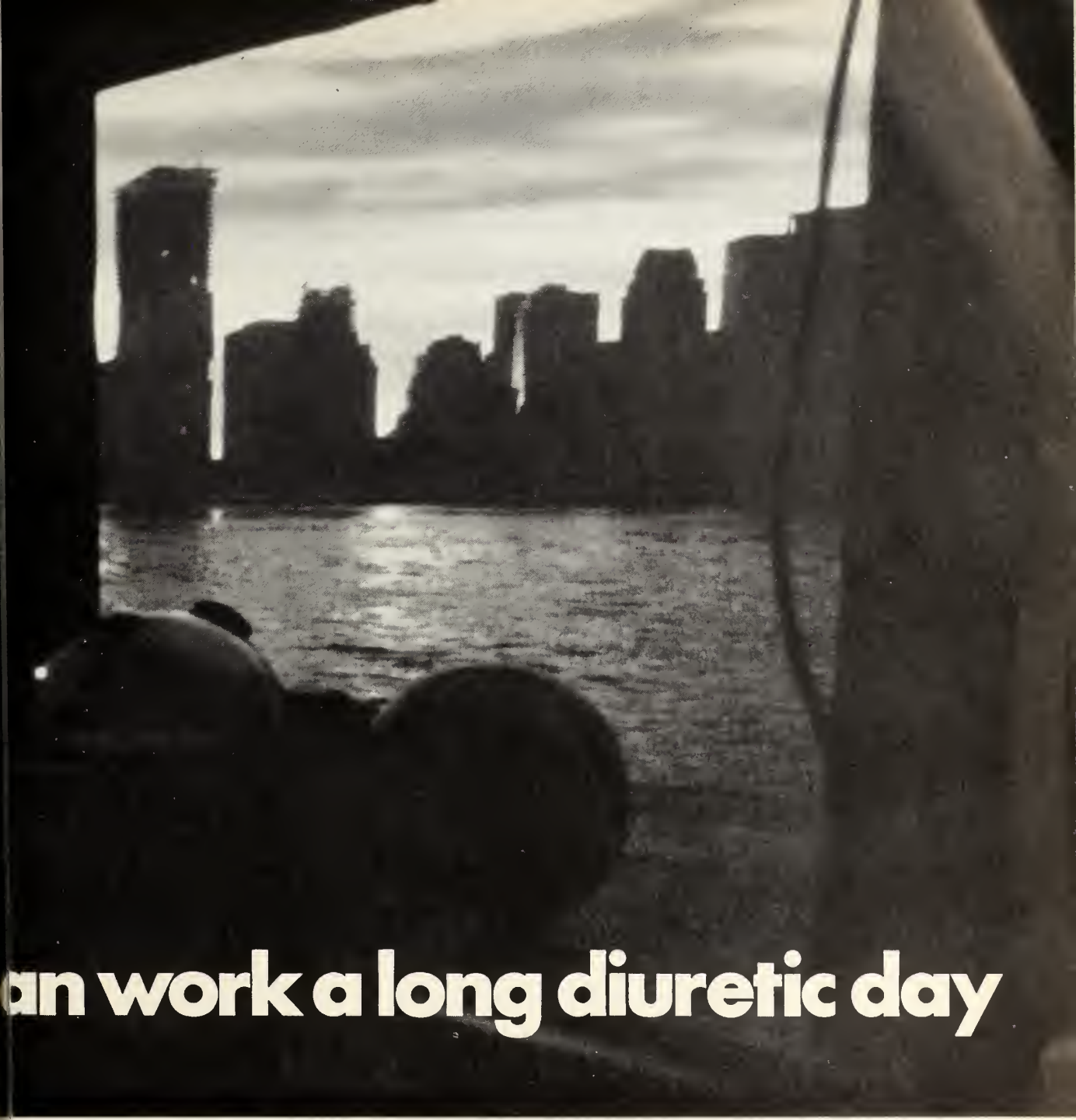
Address _____

City _____ State _____ Zip _____



A little Hygroton

chlorthalidone



an work a long diuretic day

he way from one daily tablet to the next
elp control edema and hypertension

olonged action usually provides smooth, sustained diuretic
iveness; real one-a-day dosage, right from the start; convenience
conomy.

oton, chlorthalidone, can cause side effects. And it's contra-
ated in hypersensitivity to the drug and severe renal and
tic diseases.

the prescribing information. It's summarized on the next page.

Geigy



A little Hygroton® can work a long diuretic day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)46-230-E

For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

HY-6674

Case Histories In 1968 Malaria Outbreak In Chambers

By: John A. Hermos, M. D.; George U. Fisher, M. D.; Myron G. Schultz, DVM, M. D., Parasitic Diseases Branch, NCDC and Glen E. Haughie, EIS Officer, New York State Health Department

On August 21, 1968, Dr. W. J. Donald, called the National Communicable Disease Center to report three cases of probable introduced malaria in teenagers in eastern Alabama. The diagnosis was made and treatment started at the Chambers County Hospital by Dr. J. K. Herring of Lafayette. The Alabama State Health Department laboratory confirmed the identified parasite as *Plasmodium vivax* in all three cases. Concurrently a fourth case of probable introduced malaria in a teen-age girl was reported in New York State. This girl had been in eastern Alabama prior to the onset of the disease. *P. vivax* was confirmed in this patient.

The Parasitic Disease Branch, National Communicable Disease Center provided this epidemiological report:

Case Histories

Case 1

M. W., an 18-year-old male college student, first experienced headache and backache on August 8, 1968. Two days later he developed intermittent episodes of fever, chills and diaphoresis. On the afternoon of August 10, he went to the emergency room of a local hospital, and received symptomatic treatment. The episodes became more intense, with temperature elevations to 104°F. He was hospitalized at the Chambers County Hospital on August 12. From August 12 through August 15, the episodes of fever occurred daily between 5 and 6 p. m. *Plasmodium vivax* parasites were identified in his blood smears on August 15. He was treated with chloroquine, 1500 mg. base over three days, followed by primaquine 15 mg. daily for fourteen days. He made a rapid recovery and was discharged on August 20.

Case 2

D. D., the 18-year-old girl friend of M. W., became ill on August 12, 1968 with an upset stomach, headache and fever. That evening she was amditted to a local hospital, but was discharged the following morning when she was afebrile. She again developed episodes of fever, chills and diaphoresis and was hospitalized at the Chambers County Hospital on August 14. When it was found that her boyfriend, M. W., had malaria, *Plasmodium vivax* parasites were looked for and found in her blood smear. She was similarly treated with chloroquine and primaquine, and she made a rapid recovery.

M. W. and D. D. dated regularly and their activities prior to the onset of their illnesses can be summarized together. M. W. lived in Waverly, Alabama, located on the border of Chambers, Tallapoosa, and Lee counties. He attended a local Junior college in the mornings. D. D., a recent high school graduate lived in Camp Hill, a few miles from Waverly, in Tallapoosa County, Alabama. Their afternoons were generally spent fishing at a pond near his home or at a private lake. They would always return home before sundown. On some Tuesday and Friday evenings, M. W. would play softball in Dadeville, Alabama and D. D. would watch the games. They also regularly attended the Auburn-Opelika Drive-In Theater, and did so on

Friday, July 12, and on Saturday evenings, July 20, and 27, and August 3 and 10.

Case 3

T. B., a 16-year-old high school student, first noted headache and fever on August 12, 1968, and for the following five days developed nightly episodes of fever, chills and diaphoresis. He was hospitalized on August 18, and the diagnosis of *P. vivax* malaria was made on August 19. He received chloroquine and primaquine, and had an uneventful recovery.

T. B. attended high school in Auburn, Alabama and did not know either M. W. or D. D. He spent the summer working in his father's sporting goods store. From July 14 to July 28, he was punished by his parents and was not allowed out of the house in the evenings. On Sunday evening, July 28, he attended the Auburn-Opelika Drive-In Theater with a date. On July 29, 30, and 31, he spent evenings at an indoor dance and at friends' homes. He traveled to Athens, Ga., from August 1 to 4 and to New Jersey from August 6 to 11. He did not play softball in Dadeville, Alabama, and had not been there during the month prior to his illness. On August 15, three days after the onset of his illness, he and a friend camped at Chimney Rock, an island at Lake Martin in Tallapoosa County. He was febrile that evening but remained on the island and slept out in a tent. He returned home the following day.

Case 4

L. H., a 15-year-old girl, unlike the other patients, was not a resident of Alabama. However, she did visit Alabama from July 20 to August 11, 1968, and stayed with relatives in Opelika. She first became ill with fever on August 10, but returned to her home in western New York State on the following day. From August 12 to August 16 she experienced nightly episodes of fever to 104° to 106°F. She was hospitalized on August 16, and the diagnosis of malaria was made shortly thereafter. She was treated with chloroquine but did not receive radical curative therapy with primaquine.

L. H. spent most of her vacation in Opelika. On August 3rd and 4th, she camped near Blue Creek, and on August 9, visited Columbus, Ga. She attended the Auburn-Opelika Drive-In Theater with friends on July 26 and August 2; and on the evening of August 10, after her first febrile episode, she again went to the drive-in theater.

Epidemiology

None of the patients had been in malarious areas, received blood transfusions or used common syringes. The only factor that all patients had in common was attendance at the Auburn-Opelika Drive-In Theater in Auburn, Alabama, on the weekend of July 26-28 (Figure 1). L. H. attended on July 26; D. D. and M. W. attended the theater together on July 27, and T. B. attended on July 28. Although they attended the same drive-in theater at other times during the summer, each patient attended only once during that week. The average time from attendance at the drive-in until onset of symptoms was 14.5 days (12 days for M. W., 15 days for T. B. and L. H., and 16 days for D. D.). The average incubation period for mosquito induced experimental *P. vivax* infections is 14 days and the range for 95 per cent of cases is 9-18 days.

During the early part of their illnesses, but prior to diagnosis, three of the patients were potentially re-exposed to mosquitoes. M. W. and L. H., although they were unknown to each other, both returned to the drive-in theater on August 10. D. D. also returned to the theater on August 10, but this was two days prior to the onset of her clinical illness. T. B. camped out overnight at a nearby fishing area on August 15, during the third day of his illness.

Transmission Site

The Auburn-Opelika Drive-In Theater is located between the cities of Auburn and Opelika in Lee County on Alabama State Route No. 29 (Figure 2). It occupies five acres and accomodates 700 cars. The grounds are well maintained and there are no collec-

(Continued on Pape 63)

Dulcolax®...so predictable you can almost set patients by it.

Dulcolax works so effectively that the time of bowel evacuation can often be predicted.

Dulcolax tablets taken at night will usually result in a convenient bowel movement the following morning. Dulcolax suppositories generally work within 15 minutes to an hour.

Dulcolax may be given to the aged, pregnant or nursing women, and children. It may be particularly helpful in conditions in which straining should be avoided. The drug, however, is contraindicated in the acute surgical abdomen.

Dulcolax® bisacodyl



ER LICENSE FROM BOEHRINGER INGELHEIM G.M.B.H. GEIGY PHARMACEUTICALS, DIVISION OF GEIGY CHEMICAL CORPORATION, ARDSLEY, NEW YORK 10502 DU-6681



Clues to PVD: The geriatric smoker

In studies on peripheral vascular disease—a common by-product of the degenerative aging process—considerable attention has focused on the important role of smoking in the progression of the disease. Although it may not be etiologic, smoking is widely recognized as a prominent contributing factor.[1]

Skin blood flow—significant factor in PVD. Cutaneous digital vasoconstriction caused by nicotine has been observed both in normal subjects and in patients with peripheral vascular disorders.[1,2] Among patients with peripheral vascular disease, however, age and the severity of the disease appear to modify the effects of nicotine. For example, in a study of older patients with *marked* peripheral vascular disease,[3] changes induced by smoking were not statistically significant for the group as a whole. This was explained on the basis of decreased skin reactivity. *Smoking is not permissible in any stage of the disease,* since even "... minimal reduction in blood flow in patients with ischemic limbs may produce a further reduction in tissue nutrition, and thus may be another case of the proverbial straw on the camel's back."[3]

In another study of patients with peripheral vascular disease,[4] the investigators stress that decreased skin blood flow during smoking "... is the factor of most importance to the patient with peripheral vascular disease." *While such patients may adjust to the discomfort of vascular insufficiency in skeletal muscle, decreased skin blood flow may often lead to severe symptomatology.*

More and more physicians have adopted the practice of investigating for peripheral vascular disorder when confronted with a geriatric patient who is a habitual smoker. Once a diagnosis is established, therapeutic measures are directed toward increasing the peripheral circulation and appropriate management of the patient's general medical needs. These include the important safeguards of keeping warm and refraining from smoking.

Professional model posed for illustration.

Important in total management of peripheral vascular disease, vascular spasm or chilblains

Roniacol® Timespan®

(nicotinyl alcohol tartrate)

for relief of ischemic symptoms

onvenience of b.i.d. dosage—sustained-release Timespan Tablets usually provide
olonged relief of ischemic symptoms with two doses daily.
moothness of onset—the action of Roniacol (nicotinyl alcohol) is smooth and gradual
onset, rarely causing severe flushing.
lectivity of action—relaxes the musculature of peripheral blood vessels.
igh degree of safety—side effects seldom require discontinuation of therapy.

efore prescribing, please consult complete product information, a summary of which follows:
dications: Conditions associated with deficient circulation; *e.g.*, peripheral vascular disease, vascular spasm,
ricose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo.
ution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.
le Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients,
dom requiring discontinuation of the drug.
osage: 1 or 2 Timespan Tablets morning and night.
ow Supplied: Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt, bottles of 50.

ferences: (1) Roth, G. M.; Shick, R. M., and Secrest, R. R., in James, G., and Rosenthal, T., .: *Tobacco and Health*, Springfield, Ill., Charles C Thomas, 1962, pp. 311-322. (2) Entmacher, P. S.: c. Med. Sect. Amer. Life Convention 51:149, 1963. (3) Freund, J., and Ward, C.: Ann. New York Acad. . 90:85, 1960. (4) Coffman, J. D., and Javett, S. L.: Circulation 28:932, 1963.

ROCHE
Roche LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests: they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.



(Continued from Page 58)

tions of water on the premises. There is a large, well-lighted, indoor refreshment stand at the rear center of the theater, behind which are covered garbage cans and an open incinerator pit.

In the immediate vicinity of the theater, there are several wooded and open areas. Approximately 100 yards south of the theater, there is a small creek which runs through a culvert under the highway. In addition, there are at least eight ponds in the pastures and golf courses surrounding the theater.

There are a number of drive-in snack bars, small stores and a shopping center along Highway 29, in the vicinity of the theater. There are also trailer courts within a mile radius of the theater that contain approximately 450 trailers. Behind the theater there are several residential streets with about 30 homes. Many of the residents of the trailer courts are university students, and there is a rapid turnover of population, especially in the summer months. The campus of Auburn University and the main residential areas of Auburn (combined population 16,000), and Opelika (population 15,000) are 3 and 4 miles from the theater. A large Army base, Ft. Benning, is approximately 30 miles away, and several other military installations in eastern Alabama are within 100 miles. (Figures 2 and 3)

Case Detection Activities

Attempts were made to detect additional cases of malaria which may have been related to the four introduced cases. Three categories of cases were considered:

1) Additional first generation cases

2) Second generation cases

3) The index case

The theater and other nearby establishments attracted patrons from a wide area. In fact, two of the four teenagers lived in counties outside of Lee County. In order to notify physicians of this episode of local malaria transmission, and to survey for additional cases all of the physicians in a five-county area of east-central Alabama, Lee, Chambers, Macon, Russell and Tallapoosa counties, were contacted. These counties have a population of approximately 200,000 within a radius of 25-50 miles of the theater. Ninety-seven physicians were contacted. Only two cases of unexplained fever were reported, but on subsequent examination the illnesses were not malaria and neither person had been within the area of transmission. A review of inpatient and clinic records at Auburn University, and a follow-up of fever cases previously seen at the University failed to reveal additional malaria cases. In addition, the Malaria Surveillance Unit, NCDC, had not received reports of other civilian cases of *P. vivax* malaria which could be related to this outbreak.

Since three of the teenagers had been potentially re-exposed to mosquitoes after their onsets but prior to therapy, physicians and public health officials were made aware of the possibility that second generation cases might occur. These would have occurred no sooner than early September 1968. No second generation cases have been detected by local physicians or reported to the Malaria Surveillance Unit since that time.

To identify the likely index case in this outbreak, it was necessary to establish that an infected person was within approximately a mile of the drive-in theater, during the appropriate time period. This time period can be determined with reasonable certainty. The extrinsic incubation period of *Plasmodium vivax* is temperature-dependent. For *P. vivax* this phase ranges from 7 days at a mean temperature of 28°C. to 55 days at a mean temperature of 16°C. The mean daily temperature at the Opelika Airport from July 1 to July 26 was 78°F. (25.5°C.) and from July 16 to July 26 was 79.5°F. (26.4°C.). At these temperatures, the minimum extrinsic incubation period would have been approximately 9-10 days in duration. Since L. H. became infected on the night of July 26, transmission

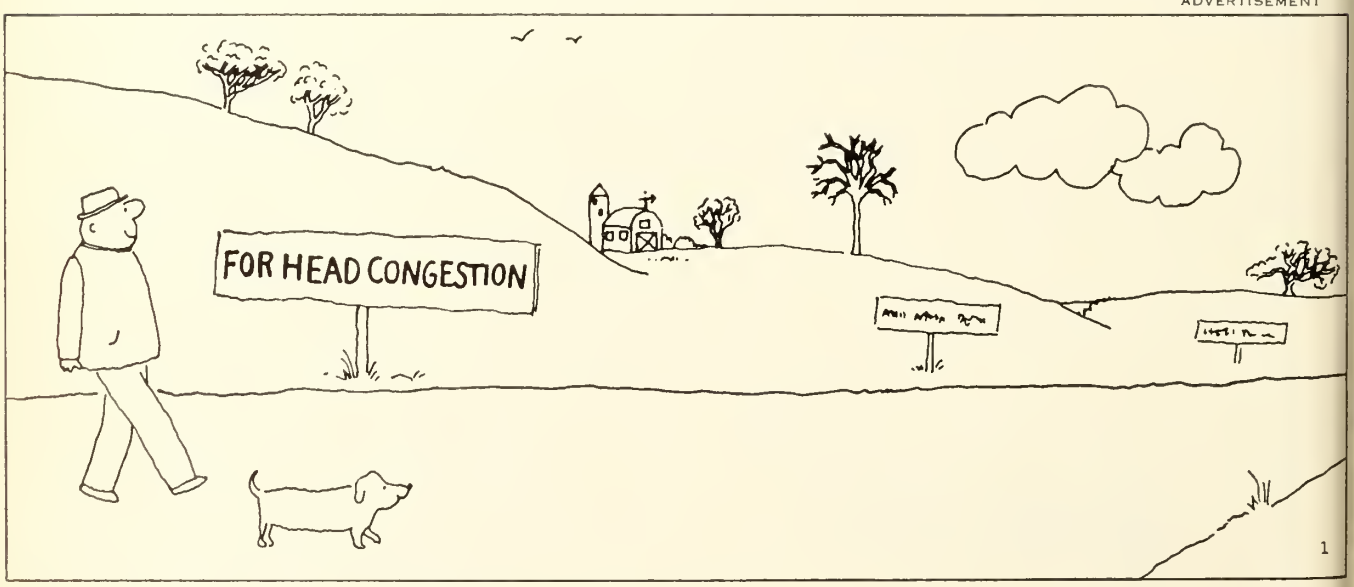
of malaria parasites from the index case to mosquitoes had to have occurred prior to July 18. Determination of the earliest time of transmission is less certain since the female mosquito may harbor malaria parasites for its entire egg-laying life. However, this period does not generally exceed 30 days, so it is unlikely that transmission could have occurred prior to June 28. Furthermore, the four cases acquired their infections on three consecutive nights making it likely that several mosquitoes were infected and that the extrinsic incubation period was brief.

Three groups were investigated in the attempt to identify the index case. They were: 1) *P. vivax* malaria cases reported to the Malaria Surveillance Unit, NCDC, 2) military personnel at nearby Veterans Administration Hospitals and military bases that had recently diagnosed malaria or fever of unknown origin and 3) undiagnosed cases of malaria in veterans and foreign students who live in eastern Alabama and western Georgia or who attend Auburn University.

There were 208 recently returning veterans who registered at draft boards in five counties of eastern Alabama; 314 veterans and 96 foreign students who attended Auburn University during the summer quarter; and 40 ROTC personnel stationed at the University. It was not possible to interview all of these individuals, but all their names were compared to the roster of malaria cases reported to the Malaria Surveillance Unit. Many were contacted by personal or telephone interview or by a mailed questionnaire. Blood smears and serologic examinations for malaria antibodies by the indirect fluorescent (IFA) technique were performed on individuals whose travel or clinical histories suggested a malaria infection.

Forty-nine of the 96 foreign students were from countries where malaria is endemic. Forty-seven students were contacted. Three gave a history of malaria in the distant past. Two of these students had last been home in 1963 and 1965. The third had been in India in March 1968 but had been completely asymptomatic. Another foreign student, a 23-year-old man from Iran, had been experiencing fevers; but he had no prior history of malaria, and blood smears and IFA titer were negative. Twenty-eight of the 314 veterans enrolled at Auburn during the summer quarter lived within a mile of the theater, and 25 of these were contacted. Of these, seven had been stationed in malarious areas. An additional 113 veterans had entered the university on or after January 1968 (6 months prior to the time of transmission); 98 of these men were contacted and 20 had served in either Vietnam or Korea. From both groups of veterans, four men had histories warranting serologic examinations. These

ADVERTISEMENT



tests were negative. Travel and medical histories of 40 ROTC personnel stationed at Auburn University were obtained. Two of these men had malaria while in Vietnam, but they had been asymptomatic since that time and they had been in another state at the time when mosquitoes would have been infected.

Servicemen with *P. vivax* malaria who either lived in eastern Alabama and western Georgia, and cases which were diagnosed at Ft. Benning and Ft. McClellan were investigated. Investigations of 28 cases did not reveal a likely index case. In three instances, the servicemen were in this area of Alabama while clinically ill or just prior to their illness, but they were not in close proximity to the site of transmission. In two other cases, the servicemen had been treated for *P. vivax* malaria, and then spent time within the area of transmission during the month of July. Blood smears of these patients indicated that treatment had been complete, and there was no clinical or serologic evidence of recurrence.

Entomologic Aspects

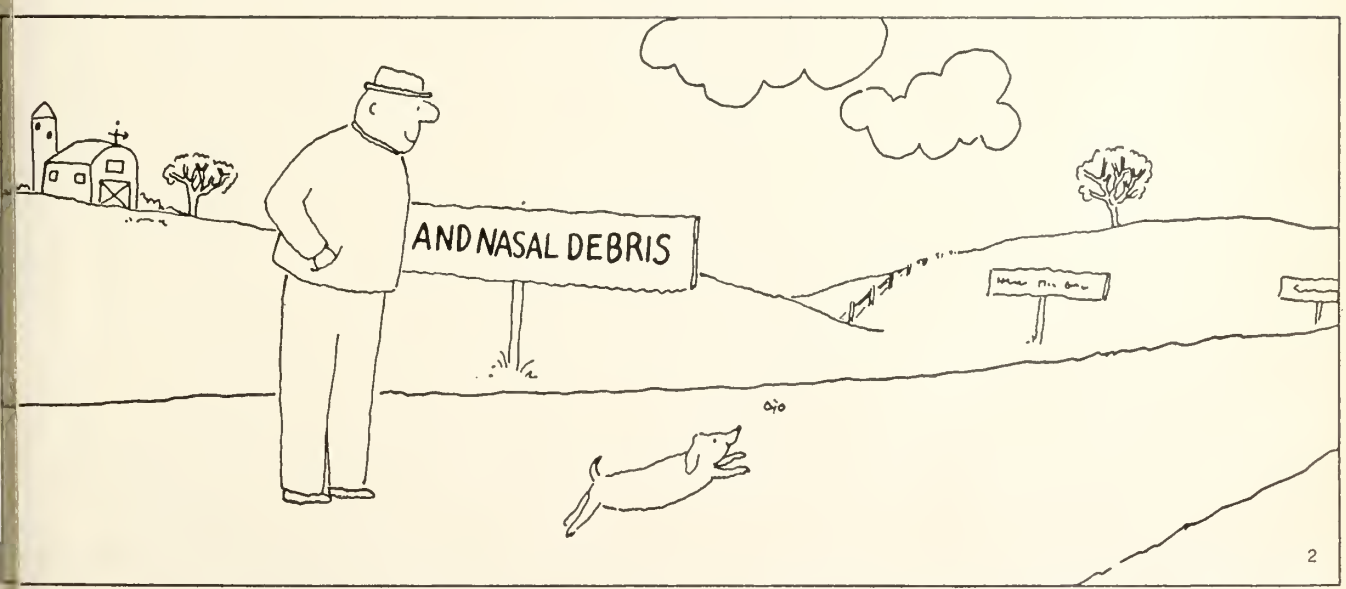
Numerous surveys of local surface water by dipping, the use of light traps, and at T. B.'s camp site indicated that *Anopheles quadrimaculatus* did exist in the area. At the time of the survey the density was very low. The condition of the ponds and the small number of larvae found suggested the potential for rapid build-up of the mosquito population was small.

In this episode of introduced malaria, the time and place of transmission was determined with certainty. Attendance at the drive-in theater was the only factor that all four teenagers had in common. Furthermore, the incubation periods of 12, 15, 15, and 16 days from the times that they attended the drive-in theater correspond closely to the average incubation period of 14 days for mosquito transmitted *P. vivax* infection in nonimmune persons.

The likely index case in this episode has not been identified. Although there is continuing screening of cases of vivan malaria reported to the Malaria Surveillance Unit, the likelihood of locating the donor by this method is decreasing as time passes. In 1967, 90.9 per cent of 2,199 imported cases of vivax malaria had the onset of illness within six months of their return to the United States. Similarly, most of the imported cases of vivax malaria now being reported are persons who returned to the United States after August 1, 1968, which is after the time transmission of malaria to the mosquitoes occurred in this episode.

Summary

In August 1968, three teenagers in Alabama



Please turn page

and one in New York State became ill with *Plasmodium vivax* malaria. Their infections were acquired by mosquito transmission at a drive-in theater in Auburn, Alabama, on three consecutive nights, and constitute introduced cases. This is the second largest outbreak of introduced malaria reported in the United States since 1944. *Anopheles quadrimaculatus* adults were trapped at the site of transmission, and are the probable vector. The index case could not be identified.

A 13-year-old Albany, N. Y., boy seeks $25,000 damages for a broken arm, received, he contends, when someone stepped on it while he was dancing to rock-and-roll music.

* * *

"The Children's Hour" in Tuscaloosa's Druid City Hospital is proving a highly successful way of opening doors inside the hospital that would otherwise be closed. For example a child, barred by age from a visit to an ill mother or sister, can hold a two-way conversation with the loved one over a closed-circuit television. Presently it is available to pediatric patients for an hour Saturday mornings, 10:30 to 11:30, and to obstetrics patients Sunday afternoons from 1:30 to 2:30. The program will be expanded.



The Month in Washington

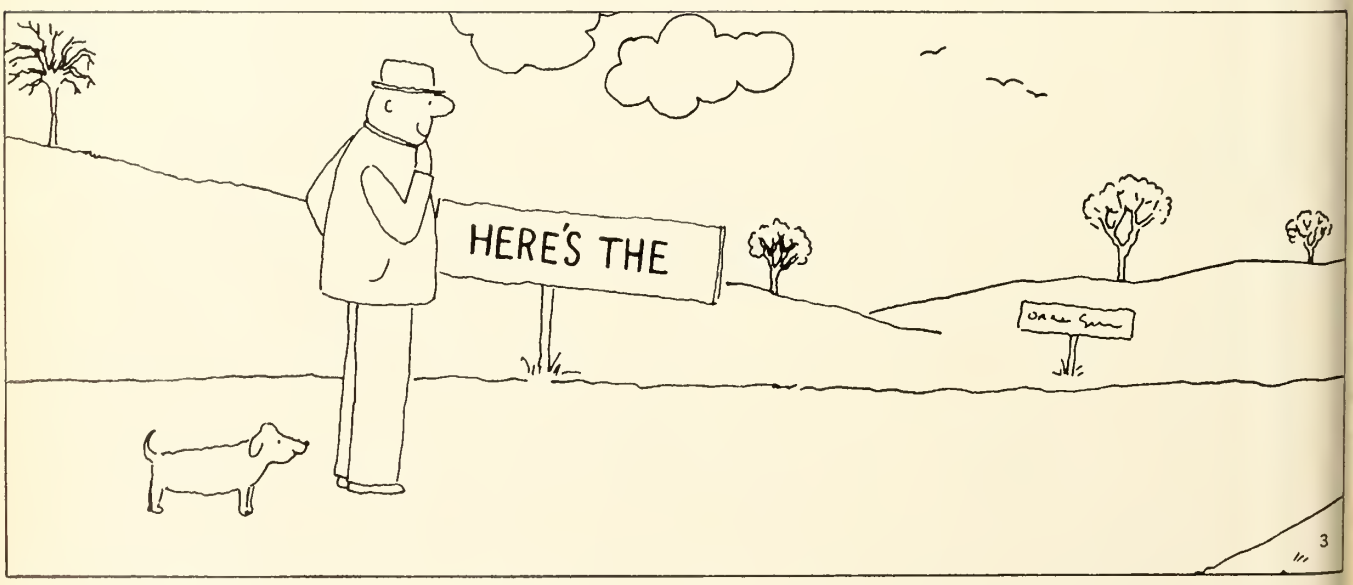
From the Washington Office
American Medical Association

Washington, D. C.—The American Medical Association has offered to cooperate in a Senate investigation of large medicare and medicaid payments to physicians and other health practitioners.

The offer followed a Senate speech by Sen. John J. Williams, (R., Del.), in which he reported that the staff of the Senate Finance Committee had found that several thousand doctors, dentists and others had received $25,000 or more for their services under the two government programs in 1968.

In a second Senate speech, Williams expressed appreciation for the AMA offer to cooperate.

"This is the type of cooperation we need,



and I appreciate this support from the American Medical Association," Williams told the Senate. "I sincerely hope that we shall have similar pledges of support from representatives of the other groups affected.

"I can assure each of these groups that our study will not result in a blanket indictment against any segment of the industry involved. We fully recognize that the overwhelming percentage of those who are in any way connected or working with this program are trying to do a good job; however, when instances of exploitation or excessive charges are discovered they must be exposed and properly dealt with."

Williams, who has announced he will not seek reelection next year, is a member of the Senate Finance Committee which is making an extensive study of the operation of medicaid and medicare.

Williams said that, although a staff report would not be ready until later this summer, the committee's investigation already had shown:—

"First, in 1968 the medicare program paid $25,000 or more to each of at least 5,000 physicians.

"Second, thousands of health practitioners —doctors, dentists, optometrists, and others —were each paid $25,000 or more under the welfare health care programs in 1968 . . . .A surprising note is the large number of dentists appearing on the lists from welfare agencies . . . .

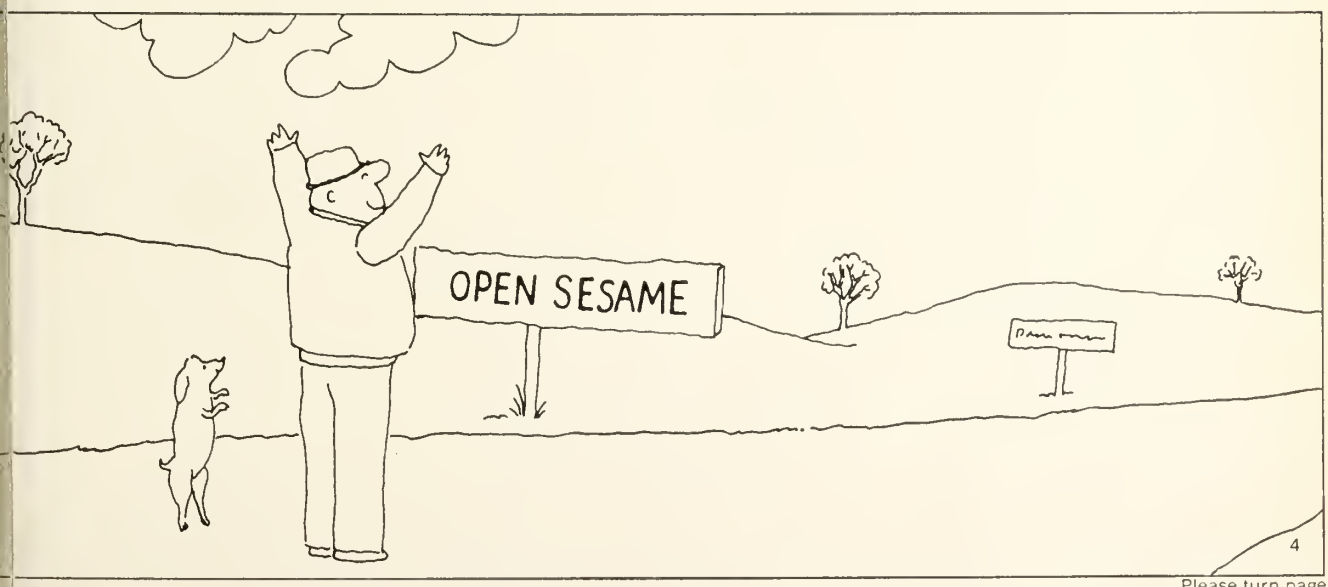
"Data has also been gathered and detailed tables prepared comparing the average medicare payments for the most common surgical procedures for older people with the maximum payments allowed under the most widely held Blue Shield contract in the same geographical area.

"The results are startling. Medicare's average payments run as much as two to four times as high as Blue Shield maximums. For example, in two areas of the country medicare's average payment for a cataract operation is more than four times as much as the Blue Shield allowance. These are not isolated cases. There is a pronounced pattern of inflated payments by medicare.

"The report to the committee will include pinpointing the causes underlying these extremely generous handouts of public funds.

"Another unusual situation has occured in Social Security's pressing carriers to pay for so-called supervisory services rendered by a teaching physician even though the actual care is provided by an intern or resident. Before medicare virtually no insurer paid for such services . . . .

"The investigation has expanded the evalu-



Please turn page

ation of carrier and intermediary performance to determine whether the Government is getting what it is certainly paying for and the extent to which intermediaries and carriers are carrying out specific functions assigned to them by the medicare statute.

"Thus far a wide variance and level of performance has been observed. . . .

"The law requires intermediaries and carriers to exercise effective controls on utilization of services. . . .

"Yet some carriers and intermediaries appear virtually to ignore performance of this vital function while others seem to be doing a reasonably effective job."

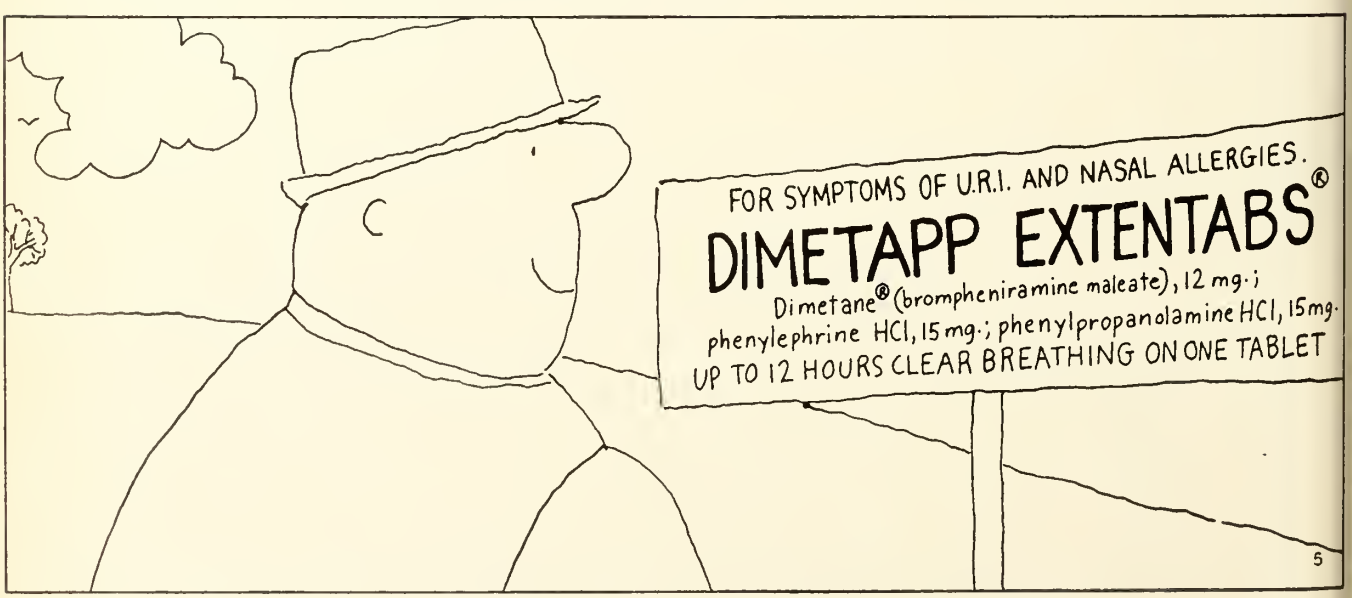
Following Williams' first speech, the AMA issued a statement saying that it shared with the Senator a concern over the rising costs of medicare and medicaid. The Association offered to cooperate with the Senate Finance Committee or any other congressional committee studying the problem of rising health care costs. The AMA earlier had made the same offer to Health, Education and Welfare Secretary Robert H. Finch.

The AMA statement said:—

"For some time the AMA has been giving national leadership in coordinating the efforts of state and county medical societies in the establishment and effective functioning of local review and utilization committees checking on the health care services rendered under the medicare and medicaid programs. Close liaison also has been established between carriers and many medical societies in reviewing disbursements under the government programs.

"All investigations so far have indicated that an overwhelming majority of physicians participating in medicare and medicaid are charging reasonable fees. The charges of only about two per cent of the physicians receiving payments from the programs have been challenged. Of course, the AMA favors appropriate action in any of the cases where physicians are found to receive improper payments. Last June, the AMA Board of Trustees urged all state and local medical societies 'to act swiftly and firmly in all instances of known exploitation, and excessive charges for health care that may occur in their jurisdiction.' In 1967, the AMA said 'any reports of abuses by physicians or by any other health care program should be thoroughly and promptly investigated and action taken where indicated.' Several medical societies have expelled members where it has been proved that a physician's charges were excessive or he in some other way exploited the program.

"The AMA, through its publications and



speeches by its officials, has been emphasizing to physicians the responsibility they have to hold down the health care costs of their patients both under and outside government programs. In an April 17 letter to Finch, Dr. Wilbur said the AMA 'is eager to make available to your office the composite experience and judgment of the nation's physicians, who are the principal providers of health care to all the people.'

"The knowledge and judgment of the nation's physicians—as well as of the prepayment plans, health insurance industry, hospitals, the allied health professions, the actuaries and others—must be enlisted in your battle against the health-care portion of the inflation problem,' Dr. Wilbur said."

* * *

The House passed and sent to the Senate a three-year $937 million extension of the Hill-Burton Act under which the federal government has helped finance construction of hospitals and nursing homes with 425,000 beds.

Members approved the measure on a 351 to 0 roll call after turning down a series of amendments designed to channel the matching hospital grants more into big cities than urban areas and into modernization rather than new hospital construction.

In addition to extending existing aid, the bill provides new loan guarantees, as requested by the Nixon Administration, and interest subsidies, which the Administration opposed.

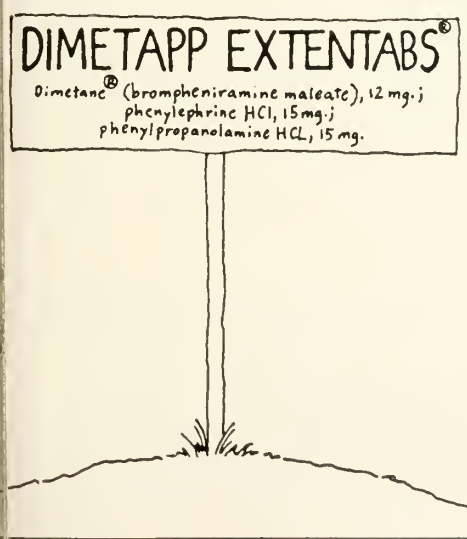
The bill as passed authorizes appropriations (over three years) up to $405 million for hospital construction; $165 million for modernization; and $300 million in guaranteed loans, toward which the government would contribute up to $37 million in three per cent interest subsidies. In addition, grants up to $30 million could be made for emergency room modernization.

* * *

The American Medical Association urged that Congress approve full appropriations for medical education programs.

Dr. C. H. William Ruhe, director of the AMA's Division of Medical Education, testified before a House appropriations subcommittee that the nation's urgent need for more physicians could "only be met effectively by a major increase in the capacity of American medical schools to educate more physicians."

"It is therefore appropriate to emphasize again that full funding in the amounts authorized by the Health Manpower Act of 1968 is necessary to permit the construction of new and expanded facilities before major enrollment increases will be feasible," Dr. Ruhe said.



INDICATIONS: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, hayfever and conjunctivitis.

CONTRAINDICATIONS: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.

PRECAUTIONS: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

SIDE EFFECTS: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.

DOSAGE: 1 Extentab morning and evening.

SUPPLIED: Bottles of 100 and 500.

A·H·ROBINS A. H. ROBINS COMPANY RICHMOND, VIRGINIA 23220

6

300 Psychiatrists Busy With Moscow's Mental Health

There are nineteen neuropsychiatric dispensaries staffed with between 15 and 25 psychiatrists each, in the City of Moscow, reports a United States Mission on Mental Health, following a visit to the Soviet Union.

Which, responds Dr. W. S. Littlejohn of Birmingham, a prominent psychiatrist-neurologist, just retired from the Medical Association's Board of Censors, is more dispensaries and more psychiatrists than are in the entire State of Alabama.



Dr. Littlejohn

"There can be no doubt that the Russians have developed a 'framework' for the delivery of psychiatric care that is remarkable to the extent that it attempts to provide—and to a considerable degree does provide—a readily available, geographically accessible network of coordinated (psychiatric) facilities.

"The key to the success of the Soviet program lies in the abundance of professional staff. The average neuropsychiatric dispensary, for example, typically has 15 to 25 psychiatrists on its staff and there are 19 such dispensaries in Moscow alone.

"The effective and large scale employment of women in the Soviet health system is especially striking. So too, is the role of the feldsher (a medical technician between the level of nurse and physician).

"The emergency system also warrants special attention. Crisis intervention . . . is an essential and critical component of the psychiatric program . . . and is richly staffed and supported. It is an enviable aspect of their program."

While the population of Moscow is some 30 per cent greater than the entire State of Alabama, the foregoing serves, Dr. Littlejohn said, to underscore some major obstacles and needs for Alabama.

It takes six to ten years to educate one doctor to the point where he is ready to begin practice, the Birmingham specialist said. Four years to a baccalaureate degree, four years to an M. D. degree, plus internship and residency are about normal. And there is the expense as well as the time involved.

He emphasized that the number of women participating in psychiatric care is a major factor in its seeming success in Russia.

Not just a motel
it's a Guest House

. . . with 171 handsome rooms designed for your comfort and convenience. A center-of-everything location including Birmingham's University of Alabama Medical Center . . . making The Guest House a favorite of Doctor's wives and in-town outpatients. Superb dining, dancing and nightly entertainment. Come stay with us often.

THE RESTAURANT
THE PLAYROOM • CYPRESS ROOM
CONVENTION FACILITIES



The Guest House
MOTOR INN

PHONE 324-8653
18TH ST. &
10TH AVE., SOUTH
BIRMINGHAM, ALABAMA

"Where the Action Is!"

"anorectal disorders"



This Rectopath Model
may help you explain
certain anorectal disorders
to some of your patients.
It is yours on request.

See next page for details.

"anorectal disorder"

includes a range of problems. For symptomatic relief in some of these disorders consider a member of the Anusol Family...

One suppository morning and evening and after each bowel movement.

ANUSOL®

soothing, palliative relief of minor pain, itching, burning, and other associated discomforts.

Each ANUSOL suppository contains bismuth subgallate (2.25%), bismuth resorcin compound (1.75%), benzyl benzoate (1.2%), Peruvian balsam (1.8%), zinc oxide (11.0%), and boric acid (5.0%), plus the following inactive ingredients: bismuth subiodide, calcium phosphate, hydrogenated vegetable oil, and coloring in a cacao butter and white wax base.

One suppository morning and evening for 3 to 5 days.

ANUSOL-HC®

prompt reduction of inflammation plus the soothing effects of regular Anusol.

Each ANUSOL-HC suppository contains, in addition to the regular Anusol formula, 10 mg. hydrocortisone acetate.

Precautions: Prolonged use of Anusol-HC might produce systemic corticosteroid effects.

One suppository every 3 to 4 hours, or every 2 hours if symptoms are severe.

ANUGESIC®

when severe pain requires prompt relief, pramoxine HCl plus the soothing Anusol formula.

Each ANUGESIC suppository contains: 61 mg. bismuth subgallate, 47 mg. bismuth resorcin compound, 32.4 mg. benzyl benzoate, 48.6 mg. Peruvian balsam, 300 mg. zinc oxide, 135 mg. boric acid, and 25 mg. pramoxine hydrochloride. Also contains the following inactive ingredients: bismuth subiodide, calcium phosphate, white wax, benzoinated lard, hydrogenated vegetable oil, and certified coloring in a cacao butter base.

Precautions: If idiosyncratic reaction occurs, discontinue medication.
Symptomatic treatment should not be allowed to delay definitive diagnosis and therapy.

Also available: ANUSOL® OINTMENT AND ANUGESIC® OINTMENT



The Rectopath Model is available from your Warner-Chilcott representative or upon request from Warner-Chilcott Labs., Morris Plains, New Jersey 07950.

Warner-Chilcott Laboratories, Morris Plains, N. J.

N-91-4C

The Book He Planned On "Serenity" May Never Be Written

Over-reacting or the "effort syndrome," which in recent years has skyrocketed the demand for sleeping pills and tranquilizers, was to have been the subject of a book.

The author was quick to admit that his easy-going manner was an acquired trait. So, in the language of the layman he purposed to tell others how to achieve serenity, how to learn to "pace" themselves.



Dr. Riggs

But Frank Willard Riggs, the soft-spoken Mississippi native who had acquired an enviable array of patients during his third of a century of dermatology practice in Montgomery, died a few weeks ago in British Columbia where he and Mrs. Riggs, the former Florence Thomas, and two other Montgomery couples were vacationing. His book will not be written, unless another attempts it.

"The pressure which makes us sick is not from the outside," he wrote, "but it is produced by the way in which we react to what is happening around us. Relaxation does not result in a state of slowing down or neglect of duties. On the contrary, tasks are accomplished in less time, fewer mistakes are made, and much more can be done."

Born in Vicksburg, Miss., Sept. 4, 1900, he attended college in that state until he volunteered in 1918 for service in the U. S. Army. Following his active duty he taught school for a year in Mississippi before entering the Medical School of the University of Virginia.

Graduated in 1925, Dr. Riggs interned in Birmingham at the T. C. I. Hospital (now Lloyd Noland) and practiced at T. C. I. for a decade. He studied under the late Dr. D. C. Smith at Virginia, and through the summer of 1936 completed his residency in Dermatology at Roosevelt Hospital, New York. In 1937 he moved with his family to Montgomery.

Dr. Riggs was an avid sportsman and an enthusiastic student of history. He was also active in community life, an Elder in Trinity Presbyterian, and for 20 years a member of the Selective Service Appeals Board.

A Life Counselor of MASA, he also was a member of the Southern Medical Association, Alabama Dermatological, Southeastern Dermatological, and the American Medical Association, a Phi Beta Pi (medical fraternity), and for more than a quarter of a century on the staff of St. Margaret's Hospital.

Services were held from Trinity Presbyterian, burial in Greenwood. Survivors include his widow, the former Florence Thomas; two sons, Frank W. Riggs III, Blucher H. Cooper, Atlanta; a daughter, Mrs. Susan Walker, Milstead; a sister, Mrs. Katherine Moore, Vicksburg; and ten grandchildren.

---

2 Far East Deans Studied Here

Two deans of dental schools in the Far East studied at the University of Alabama in Birmingham.

Dr. Isra Yuktanandana of Bangkok, Thailand, is the first graduate of the University of Alabama School of Dentistry to become dean of a school. He received his D. M. D. degree here in 1958, and is now serving as acting dean of the new Phythai School of Dentistry, Mahidol University in Bangkok.

Dr. Choon Gun Rhee, a former postgraduate student in oral surgery at the UA dental school, was recently named dean of the College of Dentistry, Seoul National University in Korea. Dr. Rhee studied here in 1958-59.

But before you prescribe Pertofrane, please see the full prescribing information and especially note Contraindications, Precautions, Warning, Adverse Reactions and Dosage. A brief summary of that information is included here.

Pertofrane® desipramine hydrochloride

Indications: For relief of depression.
Contraindications: Do not use drugs of the M.A.O.I. class with Pertofrane. Hyperpyretic crises or severe convulsive seizures may occur; potentiation of adverse effects can be serious or even fatal. When substituting this drug in patients receiving an M.A.O.I., allow an interval of at least 7 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.
Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Do not use in patients under 12 years old, and do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk.
Precautions: Careful supervision and protective measures for potentially suicidal patients are necessary. Discontinuation of therapy or adjunctive use of a sedative or tranquilizer may be necessary in the presence of increased anxiety or agitation, hypomania or manic excitement. However, phenothiazines may aggravate the condition. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Carefully observe patients with increased intraocular pressure. Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications. Cardiovascular complications (myocardial infarction and arrhythmias) are potential risks since they have occasionally occurred with imipramine, the parent compound. Desipramine may block the pharmacologic activity of guanethidine and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery in patients on desipramine therapy.
Before prescribing the drug, the physician should be thoroughly familiar with prescribing information, with the literature, with all adverse reactions, with the diagnosis and management of depression, and with the relative merits of all measures for treating the condition.
Adverse Reactions: Dry mouth, constipation, disturbed visual accommodation, anorexia, perspiration, insomnia, drowsiness, dizziness, headache, nausea, epigastric distress, and skin rash (including photosensitization) may appear. Since orthostatic hypotension has occurred, carefully observe patients requiring concomitant vasodilating therapy, particularly during the initial phases. Other adverse reactions include tachycardia, changes in EEG patterns, tremor, falling, mild extrapyramidal activity, neuromuscular incoordination, epileptiform seizures. A confusional state (with such symptoms as hallucinations and disorientation) occurs occasionally and may require reduced dosage or discontinuance of therapy. Rarely, transient eosinophilia, slight elevation in transaminase levels, transient jaundice, or liver damage have occurred. If abnormalities occur in liver function tests, discontinue drug and investigate. Occasional hormonal effects, particularly decreased libido or impotence and instances of gynecomastia, galactorrhea and female breast enlargement have been observed. Urinary frequency or retention may occur. The drug should be discontinued if agranulocytosis, bone marrow depression, jaundice, thrombocytopenia, or purpura occur.
Dosage: 25 to 50 mg t.i.d. The maximum daily dose is 200 mg. Continue maintenance dosage for at least 2 months after obtaining satisfactory response. Generally, elderly and adolescent patients should be given low doses.
Availability: Pink capsules of 25 mg in bottles of 100 and 1000 (B) 46-530-E

For complete details, please see the prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

What makes a

A man?
Another woman?
Three kids?
No kids at all?
Wrinkles?
You name it.

Is she truly depressed?

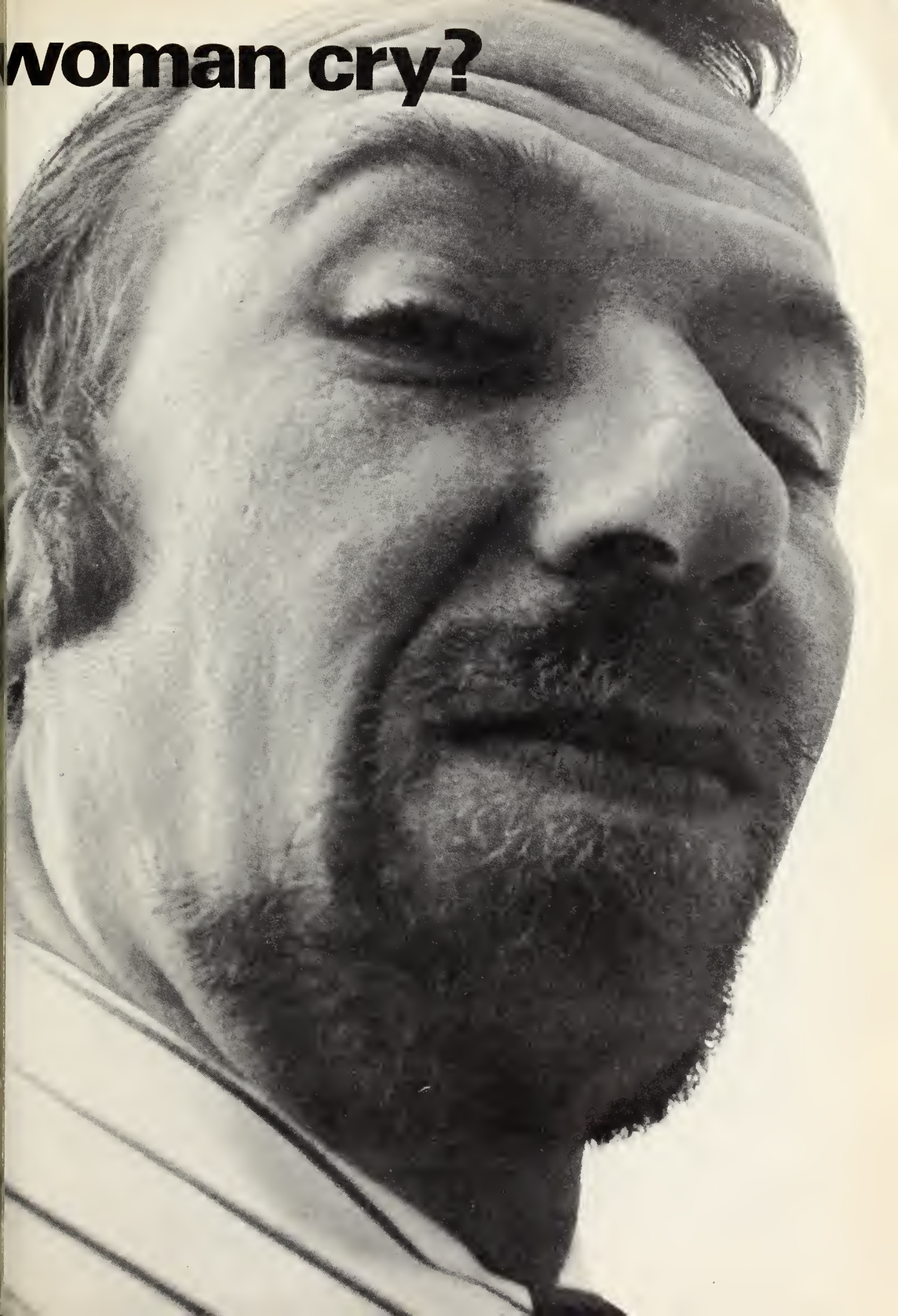
Is that why she lets go in your office?

You comfort her.
Talk to her.
And, if she is depressed, consider Pertofrane.
Because
in 3 to 5 days
she can often begin
to cope,
work,
maybe play,
even enjoy.

Pertofrane®

desipramine hydrochlori
In depression...
when words are not eno

woman cry?





around the state

Vital Statistics

NEW MEMBERS

Jefferson County

Barcia, Alberto, b 22, mc U. de La Republican 50, limited lic. 67, 1919 Seventh Avenue South, Birmingham, Ala. 35233 967-0355.

Bruhn, John R., b 34, mc Geo. Washington University 60, recip NBME 68, 920 South 18th Street, Birmingham, Ala. 35203 328-2594.

Dewees, Guy Bryan, III, b 37, mc Harvard 62, recip NBME 68, 1529 North 25th Street, Birmingham, Ala. 35234. I.

Foster, Mary Eleanor Olsen, b 31, mc College Medical Evangelists 57, recip NBME 58, 1700 Seventh Avenue South, Birmingham, Ala., 35205.

Foft, John W., b 28, mc University of Nebraska 54, recip 68, 619 South 19th Street, Birmingham, Ala., 35233 325-4713.

Gutierrez, Francisco Alberto, b 18, mc Havana U. Medical School 43, limited lic. 68, 1919 Seventh Avenue South, Birmingham, Ala., 35233.

Hinkley, Clark Miller, b 34, mc University of N. Carolina 61, recip N. C. 68, 1919 Seventh Avenue South, Birmingham, Ala., 35233 ObG.

Hudson, Bryant H., III, b 42, mc Ala. 67, sb 68, Carraway Methodist Hosp., Birmingham, Ala., 35234.

Hukill, Peter Biggs, b 27, mc Yale 53, recip NBME 68, 1919 Seventh Avenue, Birmingham, Ala., 35233. Path.

Kappen, Franklin E., b 26, mc LSU 52, recip La. 68, 1529 North 25th Street, Birmingham, Ala. 252-6121.

Kilic, Nizamettin, b 20, mc University of Istanbul 44, sb 68, 1529 North 25th Street, Birmingham, Ala., 35234.

Luketic, Gorazd Christopher, b 23, mc University Zagreb Yugoslavia 46, sb 68, 1919 Seventh Avenue South, Birmingham, Ala., 35233.

McLarey, Don C., b 40, mc University of Arkansas 65, recip Ark. 66, 1633 25th Street, Birmingham, Ala., 35234.

Packard, John M., b 20, mc Harvard 45, recip Fla. 68, 1919 Seventh Avenue South, Birmingham, Ala., 35233.

Riley, William Earle, b 37, mc Ala. 62, sb 63, Lloyd Noland Hospital, Fairfield, Ala., 35064.

Schnaper, Harold Warren, b 23, mc Duke 49, recip NBME 68, 1919 Seventh Avenue South, Birmingham, Ala., 35233.

Williams, James R., b 36, mc Ala. 62, sb 63, 1321 South 19th Street, Birmingham, Ala., 35205. 328-0117.

Madison County

Marcus, Elliot Lee, b 39, mc Duke 63, recip. North Carolina 68, 930 Franklin Street, Suite 207, Huntsville, Ala., 35801.

(Continued on Page 79)



Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL PEN•VEE® K

(potassium phenoxymethyl penicillin) Wyeth



The Fortunate One.

Her urinary tract infection reveals itself through pain and discomfort.

While the pain and discomfort of a G.U. infection are anything but pleasant, the patient may be luckier than she realizes. That burning sensation (and/or frequency, urgency, dysuria) is a usually reliable sign of a urinary tract infection. And it's her good fortune that her infection won't go undetected...or untreated.

Azo Gantanol® therapy usually provides analgesic action within one-half hour, while control of the infection begins within two hours. Azo, a specific urinary analgesic, soothes inflamed mucosa to give symptomatic relief. At the same time, the antibacterial component, Gantanol (sulfamethoxazole), achieves therapeutic levels in the blood and urine, with diffusion into interstitial fluids. Azo Gantanol—a good choice when urinary tract infection reveals itself through symptomatic distress.

Before prescribing, please consult complete product information, a summary of which appears on opposite page.

Azo Gantanol®

(Each tablet contains 0 5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.)

Azo for the pain
Gantanol®
(sulfamethoxazole)
for the pathogens

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Urinary tract infections with associated pain or discomfort when due to susceptible organisms; prophylactically in urologic surgery, catheterization and instrumentation.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

Dosage: Adults—4 tablets initially, then 2 tablets morning and evening.

How Supplied: Tablets, bottles of 50.



Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

(Continued from Page 76)

Tallapoosa County

Michaels, Lawrence, b 33, mc McGill 59, recip 68, 202 Seventh Street, West End, Alexander City, Ala., 35010.

Warr, Lloyd C., b 33, mc Ala. 58, sb 59, Alexander City, Ala., 35010.

CHANGE OF ADDRESS OF MEMBERS

Calhoun County

Woodruff, Gerald G., present Montvue Road, Anniston to 721 East 10th Street, Anniston, Ala., 36201.

Dallas County

Henderson, Robert J., Jr., present Dallas Ave., Selma to Doctors Park, New Orrville Road, Selma, Ala., 36701.

Etowah County

Graves, Robert S., present 14th Street, to P. O. Box 1828, Gadsden, Ala., 35901.

Houston County

Greenfield, William R., Jr., present West North Street to Box 1629, Dothan, Ala., 36301.

Jefferson County

Briggs, Dick D., Jr., present Birmingham to 2925 Southwood Road, Mountain Brook, Ala., 35233.

Carter, Melson Barfield, present Highland Avenue to 4244 Silver Court, Birmingham, Ala., 35213.

Merck, Daniel E., present Seventh Avenue to 711 South 21st Street, Birmingham, Ala., 35233.

Ott, W. Rodney, present Birmingham to 7832 2nd Avenue South, Birmingham, Ala., 35205.

Lauderdale County

Langstaff, Quintus Aden, present Route 7, Box 317 to 438 North Seminary Street, Florence, Ala., 35630.

Madison County

Browning, Russell L. present Laurel, Md., to 205 St. Clair Avenue, Huntsville, Ala., 35801.

Cameron, William B., present Franklin Street to 201 Longwood Street, Huntsville, Ala., 35801.

Smith, Mary Joyce, present Franklin Street to 2329 Whitesburg Drive, Huntsville, Ala., 35801.

Mobile County

Amendola, Arthur A., present First National Bank Building to 263 St. Francis, Mobile, Ala., 36601.

Cooner, William H., present Springhill Ave. to 1720 Center Street, Suite 103, Mobile, Ala., 36604.

Montgomery County

Brown, Harold W., present Birmingham to 361 South Ripley Street, Montgomery, Ala., 36109. (transfer from member Jefferson to member Montgomery County)

Lawrence, Ralph L. present State Office Building to 3424 Le Bron Court, Montgomery, Ala., 36111.

Martin, Farris J., present Bell Building to 359 South Ripley Street, Montgomery, Ala., 36104.

Page, Thomas N., present 3721 Thomas Avenue, Montgomery to P. O. Box 2932, Portland, Oregon 97208.

DEATHS

Jefferson County

Terrill, James W., 3120 Avenue H., Ensley, Birmingham, Ala., deceased.

Montgomery County

Riggs, Frank W., 750 Washington Avenue, Montgomery, Ala., deceased May 22, 1969.

NON-MEMBERS TRANSFERRED

Jefferson County

Abernathy, Frank, Jr., present Route 5 Gadsden to 2030 Montreat Parkway, Birmingham, Ala., 35216.

CHANGE OF SPECIALTIES

Jefferson County

Ott, W. Rodney, 7832 - 2nd Ave., South, Birmingham, change to ENT.

Shepard, Richard B., 1919 Seventh Avenue South, Birmingham, Alabama present S, change to S-THS.

Mobile County

Erwin, James H., 1507 Springhill Avenue, Mobile, Ala. present S-PdS, change to PdS.

Montgomery County

Montgomery, Hubert T., 2119 East Blvd., Montgomery, present GP, change to S.

NEW COUNTY SOCIETY OFFICERS

Tuscaloosa County

President ..... Dr. W. C. Folsom
President Elect ..... Dr. T. H. Patton
Secretary-Treasurer ..... Dr. George Cooper

NEW TELEPHONE NUMBERS

H. Dale Brown, Birmingham 328-2594
B. L. Landers, Birmingham 328-2594
H. T. Montgomery, Montgomery 288-7411

(Continued on Page 85)

the complex picture
moderate to severe anxiety...



ere is a new reason
r prescribing Mellaril
(Thioridazine HCl)

fectiveness in
xed anxiety-depression

r recognized for its usefulness in the
ment of moderate to severe anxiety,
aril is now also known to be effective
st mixed anxiety-depression.

n the symptoms of anxiety states are
ult to sort out—even with the most careful
ng. The patient may manifest symptoms of
ion, restlessness, insomnia, somatic
laints. But what of the depression that may
xed in the total picture? It is reassuring
ow that Mellaril may be prescribed—with
g possibilities of success—when there is
ty alone or a mixture of anxiety
epression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-169



...now fast relief of hay fever symptoms with

NTZ®

Nasal Spray



Winthrop

When pollens fly, just one or two squirts of NTz in each nostril, followed in a few minutes by a second spraying, shrink swollen nasal passages almost on contact. And breathing comfort follows. The antihistamine component of NTz helps combat the allergic reaction and lessen rhinorrhea, sneezing and itching; its antiseptic wetting agent promotes rapid spread of components.

NTz Nasal Spray affords the well-known benefits of Neo-Synephrine® in a carefully balanced formula which includes:

Neo-Synephrine® (brand of phenylephrine) HCl, 0.5% (adult strength), decongestant
Thenfadil® (brand of thenyldiamine) HCl, 0.1%, antihistamine
Zephiran® (brand of benzalkonium as chloride, refined) Cl, 1:5000, antiseptic wetting agent

Treatments with NTz should be repeated every three or four hours as needed. NTz is for temporary relief of nasal symptoms and overdosage should be avoided. Available in squeeze bottles of 20 ml. and 1 oz. bottles with dropper.

Winthrop Laboratories, New York, N.Y. 10016 (1289M)

When it's more than a bad cold



your patient can feel better while she's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg., Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

32-8

now she can cope...

thanks to

Butisol SODIUM®
(SODIUM BUTABARBITAL)



the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.

Alabamian To Preside Over 46th Annual Auxiliary Convention

A *quintilis* is less than a quart, you know.

Capitalized, it used to be the name for the month that Julius Caesar renamed for himself when he revised the calendar and made it the seventh instead of the fifth month.

The year is passed the halfway mark. The freshness is fading from nature, under a burning sun. The air is full of the hum of insects. Birds are darting everywhere in search of food. It is the season of the abundant life, when a child in the outdoors may learn much about nature.

It is a month in which nations were born: —the United States on the 4th, Venezuela on the 5th, Haiti on the 7th, the Argentine on the 9th, France (with its Bastille Day) on the 14th, Belgium on the 21st, the Netherlands on the 25th, Peru on the 28th.

It is a month in which notables were born: Calvin Coolidge and John D. Rockefeller, P. T. Barnum and Mary Baker Eddy, David Farragut and John Paul Jones, Julius Caesar and Benito Mussolini, Sir William Oslar, the Canadian physician, and Gregor Mendel, the botanist who discovered the law of heredity.

And this year, July is when the American Medical Association Woman's Auxiliary will meet in New York City for its 46th annual convention, with an Alabamian presiding as president—Mrs. John M. Chenault of Decatur. Mrs. Chenault, as president-elect, took over the responsibilities of her office ahead of time with the death of the president, Mrs. C. C. Long of Ozark, Ark.

Dates of the convention are Sunday through Thursday, July 13-17, to be held in the Waldorf Astoria Hotel. And among the features will be a luncheon speech by AMA President Dwight L. Wilbur, M. D., on Monday; a "Show and Tell and Film Showing" on Tuesday, when State auxiliaries will be displaying their projects and/or show films produced by or for them; and Ann Landers (the Dorothy Dix of the Nuclear Age), a member of AMA's Advisory Committee on Health Care of the American People, will be one of the featured speakers.



Mrs. John M. Chenault

"Serious blood clots in women—especially women taking oral contraceptives—are concentrated in those with type A blood, a surprising new study indicates. Women who are type O, on the other hand, are remarkably safe from thromboemboli even if they are pregnant or taking the pill," says a recent *Medical World News* article, captioned "Blood Type Found Factor in Pill Hazards."

* * *

Rising maternity costs are accomplishing in some areas what warnings of our population explosion could never do. Those who pay their own way are accounting for more and more empty maternity beds in the nation's obstetrical wards, according to a report of the Connecticut Hospital Planning Commission.

An Interesting Name For An ALAPAC Director

Our surnames usually indicate our geographical or occupational origins—where our forebears came from or what they did for a living.

On that premise, one of the most interesting names in the roster of the Medical Association of the State of Alabama happens to be that of the 2nd Congressional District member of the Board of Directors of ALAPAC (the Alabama Medical Political Action Committee). He also is vice president for the Southwestern quarter of the State for MASA.



Dr. Phillippi

The ancient Thracian city from where a paternal ancester probably came was originally known as Crenides, but in 356 B. C. Philip of Macedon renamed it in honor of himself. Spectacular ruins still mark its site, some nine miles from the Mediterranean coast, and near the gold mines of Mount Pangaeus. Philip's descendants held control of it for 188 years, to 168 B. C., when it fell to the Roman conquerors.

But to move forward in history some two millennia, from the 2nd century before Christ to the 20th century anno Domini, Frank Marion Phillippi, Jr., is a native of Greenville, S. C., moved to Nashville, Tenn., as a baby, and then to Camden, Ala., at the age of nine, where his public-school education was completed before going to Auburn.

Tulane was his choice for a medical education, followed by internship in Charity Hospital, New Orleans. After that came his years of service in World War II, most of the time attached to the 112th Evacuation Hospital in the ETO (the European Theater of Operations).

After the war he returned from Europe to begin a General Practice in Brewton, Ala., where he has been ever since.

Dr. Phillippi is married to the former Virginia Kerlin, daughter of a Methodist minister, and they have two sons, Busby and Mac, ages 17 and 16, both of whom are promising athletes.

A member of the Presbyterian Church, the Brewton Rotary Club and other civic organizations, Dr. Phillippi has served twice as president of the Escambia County Medical Society. He also served for some years as chief of staff of McMillian Memorial Hospital.

Hobbies are athletics and bird dogs, one of his dogs winning the 1967 Open National championship.

There are three Phillippi brothers, one currently an Internist, practicing in Beaumont, Texas; the other, following in their father's footsteps, an insurance actuary, presently residing in Birmingham.

And to tie at least one loose thread together, linking by a name the ancient city of a Macedonian monarch and the respected City of Brewton in Escambia County, Alabama, the first Phillippi to come to this country was Dr. Bordet Phillippi, a French surgeon in the armies of Napoleon, who helped settle Sarasota, bringing with him to Florida the first citrus fruit. Sarasota has a city park named for him.

The AMBAR® SCRAPBOOK of

Obesity Oddities

FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

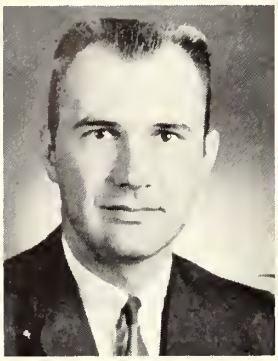
ne Ambar Extentab before breakfast can lp control most patients' appetite for up 12 hours. Methamphetamine, the appe- e suppressant, gently elevates mood and lps overcome dieting frustrations. Pheno- rbital, the sedative in Ambar, controls irritability and xiety... helps maintain a state of mental calm and equa- mity. Both work together to ease the tensions that erode e willpower during periods of dieting.

so available: Ambar #1 Extentabs®—methamphetamine drochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warn- g: may be habit forming).

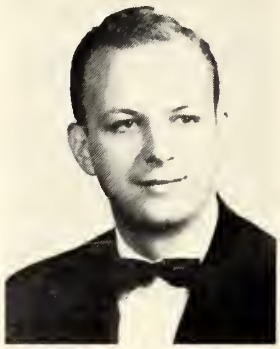
BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS

New Physicians Licensed To Practice In Alabama



Raymond Eugene Beckering, Jr., M. D., University of Michigan Medical School, 1962, Reciprocity with Michigan—Intends to locate in Birmingham.

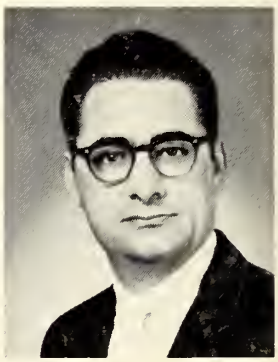


Pat Ed Burlison, M. D., University of Tennessee College of Medicine, 1960, Reciprocity with Tennessee—Intends to locate in Huntsville.

Charles Henry Behlen, II, M. D., University of Virginia School of Medicine, 1963, Reciprocity with Virginia—Intends to locate in Mobile.

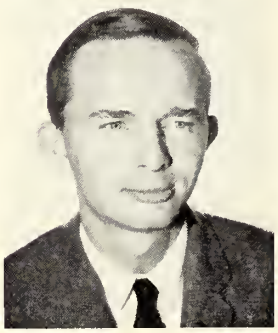


Richard Joseph Clement, M. D., Louisiana State University School of Medicine, 1963, Reciprocity with Louisiana—Intends to locate in Huntsville or Athens (stationed at Redstone Arsenal).





James Coleman Brantley, M. D., Tulane University School of Medicine, 1966, Reciprocity with Georgia—Intends to locate in Troy.

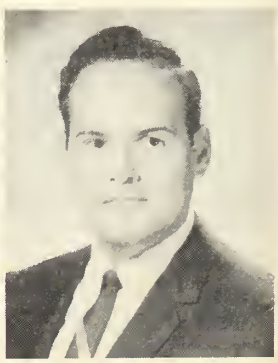


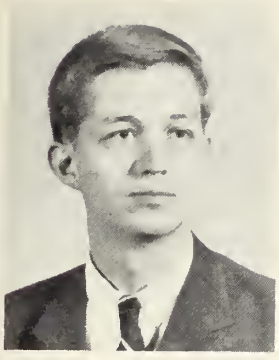
Cecil Douglas Cox, Jr., M. D., Tulane University School of Medicine, 1967, Reciprocity with Louisiana—Intends to locate in Prattville.

John Augustus Brown, Jr., M. D., University of Mississippi School of Medicine, 1960, Reciprocity with Mississippi—Intends to locate in Huntsville.



Richard Earle Dankner, M. D., State University of New York Upstate Medical Center, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Montgomery.





Peter Elwood Dorsett, M. D., University of Mississippi School of Medicine, 1965, Reciprocity with Mississippi—Intends to locate in Phenix City (Fort Benning, Ga.)



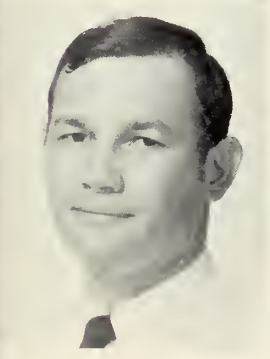
Samuel Goldman, M. D., University of Illinois College of Medicine, 1966, Reciprocity with National Board of Medical Examiners—Intends to locate in Montgomery.

Miller Bonner Engelhardt, M. D., Medical College of Alabama, 1964, Reciprocity with Louisiana—Intends to locate in Montgomery.



John Richard Gunderman, M. D., State University of New York, 1965, Reciprocity with National Board of Medical Examiners—Intends tends to locate in Montgomery.





Swepson Floyd Fraser, Jr., M. D., Tulane University School of Medicine, 1962, Reciprocity with Louisiana—Intends to locate in Mobile.



Joseph Herrin Hagood, Jr., M. D., University of Tennessee College of Medicine, 1963, Reciprocity with Mississippi—Intends to locate in Selma.

George Frederick Geils, M. D., Medical College of South Carolina, 1966, Reciprocity with South Carolina—Intends to locate in Birmingham.

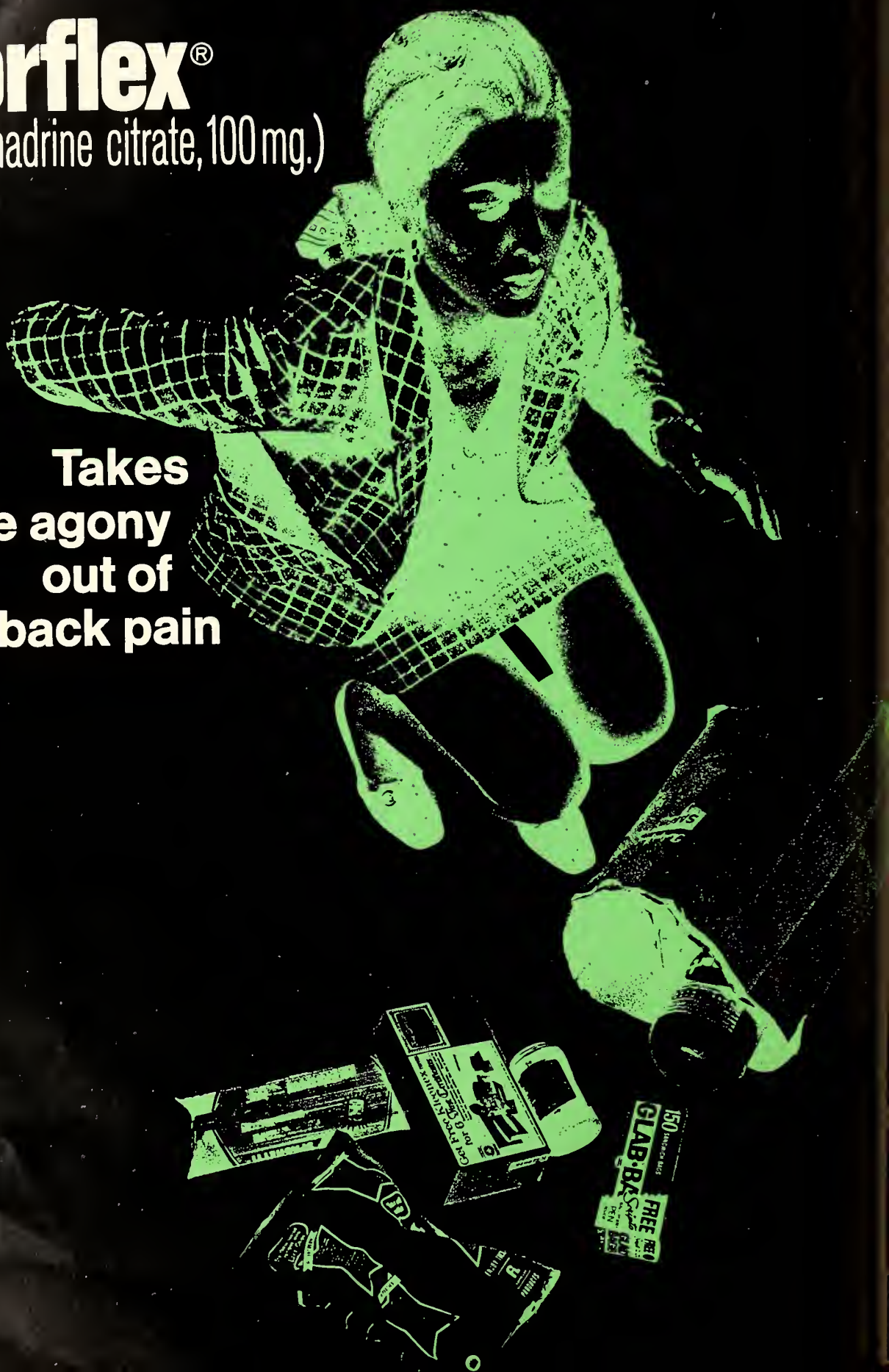


Longstreet Cavett Hamilton, M. D., Tulane University School of Medicine, 1944, Reciprocity with Mississippi—Intends to locate in Fairhope.



(Continued on Page 91)

Norflex®
(orphenadrine citrate, 100 mg.)



Take the agony out of low back pain... Norflex® (orphenadrine citrate) relaxes the muscles in spasm.

Restore mobility and hasten recovery... prescribe Norflex 1 tablet b.i.d.

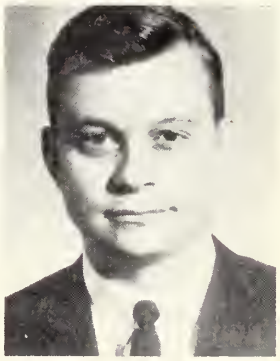
Indications: Acute spasm of voluntary muscles, regardless of location; especially post-traumatic, discogenic, and tension spasms. **Contraindications:** Due to its anticholinergic action, NORFLEX should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcer, prostatic hypertrophy or obstruction at the bladder neck, cardiospasm (megaesophagus) and myasthenia gravis. Use with caution in patients with tachycardia. Do not use propoxyphene (Darvon®) concurrently. **Adverse Reactions:** Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Adverse reactions are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported. **Dosage and Administration:** Two tablets per day for adults, regardless of weight or sex; one in the morning and one in the evening. Each tablet contains 100 mg. orphenadrine citrate.
For full information, see Package Insert or P.D.R.

Norflex®
(orphenadrine citrate)

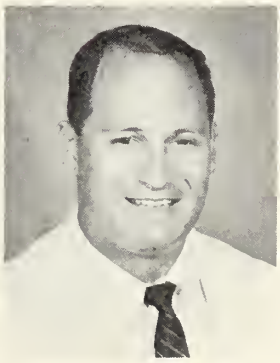
Riker Laboratories
Div. of Dart Industries Inc.
Northridge, California 91324

The Riker representatives in your area are:
Robert Johnston
Billy J. Phillips
William O. Crabb
Paul E. Loeffler III

(Continued from Page 89)



Theophilus James Humphreys, M. D., University of Tennessee College of Medicine, 1964, Reciprocity with Tennessee—Intends to locate in Ft. McClellan.



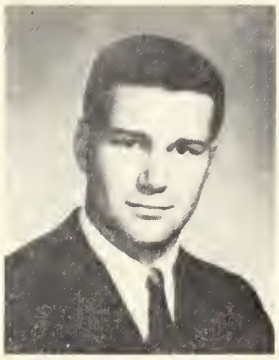
Robert Bruce Karp, M. D., University of California School of Medicine, 1958, Reciprocity with California—Intends to locate in Birmingham.



Baylor Waldmann Kurtis, M. D., Tufts University School of Medicine, 1966, Reciprocity with National Board of Medical Examiners—Intends to locate in Anniston.



Melvyn Bernard Lieberman, M. D., University of Cincinnati School of Medicine, 1964, Reciprocity with Ohio—Intends to locate in Columbus, Georgia.

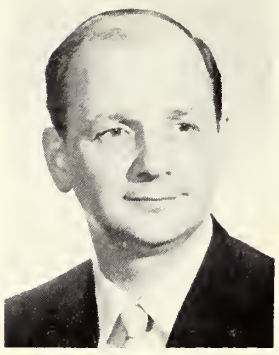


Harry Joseph Littleton, M. D., Medical College of Alabama, 1966, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Charles Fenner McConnell, M. D., Tulane University School of Medicine, 1959, Reciprocity with Louisiana—Intends to locate in Pensacola, Fla., and do relief work in Alabama.

Andrew Endre Lorincz, M. D., University of Chicago School of Medicine, 1952, Reciprocity with Florida—Intends to locate in Birmingham.



Jon Kimmerle Miller, M. D., University of Florida College of Medicine, 1967, Reciprocity with National Board of of Medical Examiners—Intends to locate in Phenix City (Emergency room relief work while stationed at Fort Benning).





Rupert Walter Lundgren, Jr., M. D., University of Texas Southwestern Medical School, 1964, Reciprocity with Texas—Intends to locate in Montgomery.



George Franklin Monzingo, M. D., Louisiana State University School of Medicine, 1961, Reciprocity with Louisiana—Intends to locate in Opp.

Billy Harold Mason, M. D., University of Tennessee College of Medicine, 1966, Reciprocity with Tennessee—Intends to locate in Birmingham.



William Gordon Moseley, Jr., M. D., Medical College of Alabama, 1966, Reciprocity with National Board of Medical Examiners—Intends to locate in Alabama (at completion of residency).



(Continued on Page 97)



The burdened heart...

The burdened heart, psychic tension, and adjunctive therapy with Valium® (diazepam):



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Artist's conception schematically showing varying ischemic ventricular muscle tissue.

To help lift psychic tension from the already burdened heart

When the cardiac patient shows signs of panic-like reactions following initial diagnosis—a daily regimen of 10-mg Valium (diazepam) tablets *t.i.d.* or *q.i.d.* can help control *severe* psychic tension, anxiety, apprehension and agitation. For *less severe* emotional stress, the 5-mg tablet usually provides the desired calming effect.

When the cardiac patient's outlook impedes convalescence—Valium, as it relieves psychic tension, can help the patient regain a realistic perspective... help him deal more rationally with convalescence by countering excessively anxious attitudes towards the future.

When the cardiac patient can't adjust emotionally to post-recovery limitations—Valium, through its prompt and pronounced calming action on psychic tension, may help avoid exacerbation or aggravation of cardiac symptoms.

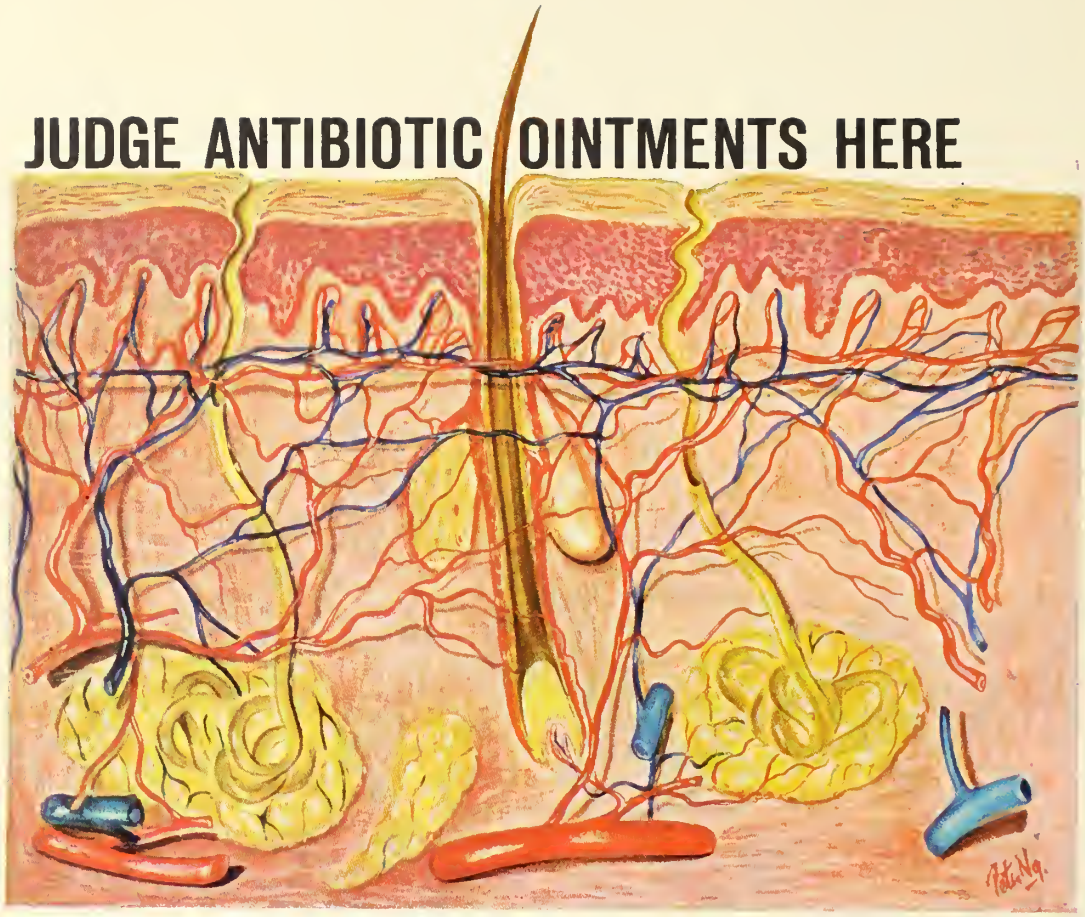
On proper maintenance dosage, Valium seldom dulls the senses or interferes with functioning.

Should anxiety-induced insomnia be a problem— an *h.s.* dose added to the *t.i.d.* schedule usually helps permit a night of restful sleep.

Valium®
(diazepam)

2-mg, 5-mg and 10-mg tablets
t.i.d. and *h.s.*

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

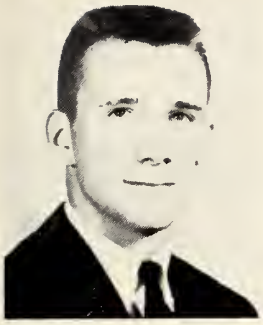
Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



John William Murphy, M. D., University of Louisville School of Medicine, 1967, Reciprocity with Kentucky—Intends to locate in Birmingham.



Harold Cotton Ray, M. D., University of Tennessee College of Medicine, 1963, Reciprocity with Tennessee—Intends to locate in Huntsville.

Hugh Bryan Noah, M. D., Bowman Gray School of Medicine, 1966, Reciprocity with North Carolina—Intends to locate in Montgomery.



David Allen Reskof, M. D., University of Pittsburgh School of Medicine, 1960, Reciprocity with Pennsylvania—Intends to locate in Huntsville.



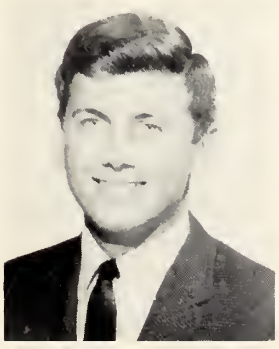


John Dee Parkinson, M. D., University of Tennessee College of Medicine, 1962, Reciprocity with Mississippi—Intends to locate in Birmingham.



Robert Edward Riederer, M. D., Olathe, Kansas, University of Kansas School of Medicine, 1942, Reciprocity with Kansas—Intends to locate in Birmingham.

Logan Postell Perkins, Jr., M. D., Tulane University School of Medicine, 1966, Reciprocity with Louisiana—Intends to locate in Birmingham.

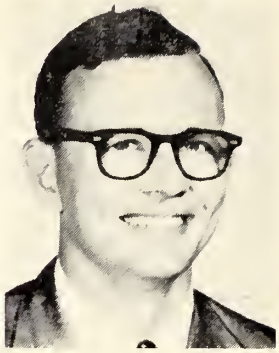


Larry Wayne Sampson, M. D., Bowman Gray School of Medicine, 1963, Reciprocity with North Carolina—Intends to locate in Birmingham.





William Burton Shadburn, M. D., Emory University School of Medicine, 1966, Reciprocity with Georgia—Intends to locate in Birmingham.

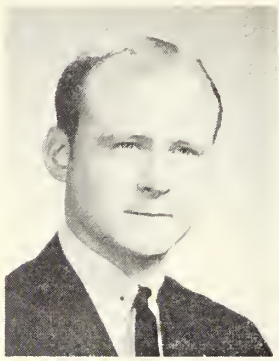


James Robert Spencer, M. D., University of Florida College of Medicine, 1965, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



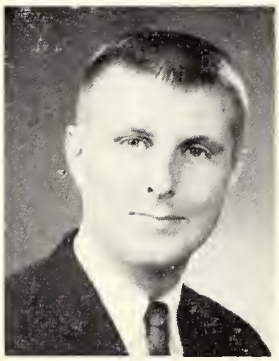
John Michael Spring, M. D., Georgetown University School of Medicine, 1962, Reciprocity with National Board of Medical Examiners—Intends to locate in Montgomery.

Patrick Francis Sheedy, M. D., University of Pennsylvania School of Medicine, 1964, Reciprocity with National Board of Medical Examiners—Intends to locate in Montgomery.





James Edward Stamm, M. D., Indiana University School of Medicine, 1964, Reciprocity with Indiana—Intends to locate in Mobile.



Claude Wilson Smith, Jr., M. D., Medical College of South Carolina, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.

Jack Cannon Whites, M. D., University of Mississippi School of Medicine, 1959, Reciprocity with Mississippi—Intends to locate in Birmingham.





James Wolfe Solomon, M. D., University of Miami School of Medicine, 1959, Reciprocity with National Board of Medical Examiners—Intends to locate in Montgomery.



Andrew Allen Windham, M. D., University of Tennessee College of Medicine, 1945, Reciprocity with Mississippi—Intends to locate in Russellville.

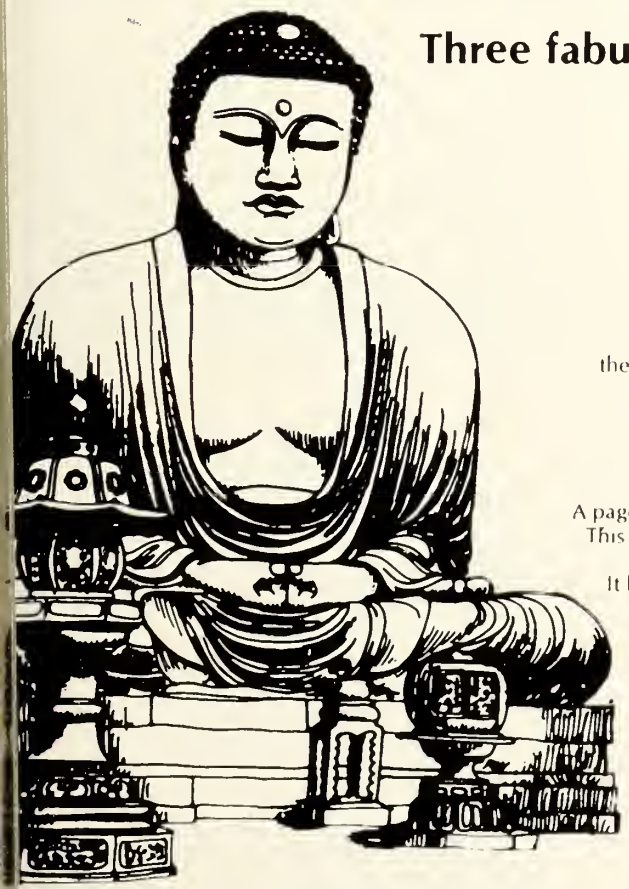
Now available to members of

THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

and their immediate families

ORIENTAL CARNIVAL®

via Trans International Airlines (a certificated supplemental carrier)



Three fabulous vacations in one 14-day trip!

6 days and nights at the beautiful New Otani Hotel in

TOKYO

where the ancient and modern, the East and West collide in a chaotic jungle of styles

2 days and nights at the luxurious Mandarin Hotel in

TAIPEI

the beautiful capital city of Nationalist Chinese Taiwan where city and country merge in a personification of Old China.

6 days and nights at the world famous Hong Kong Hilton in

HONG KONG

A pageantry of color, charm and grace, Hong Kong is truly unforgettable This fascinating British colony where 99% of the population is Chinese literally and figuratively rises from the sea. It boasts one of the world's great natural harbors and busiest seaports where freighters and luxury cruisers arrive from all over the world and where more than 150,000 people use their boats as floating homes, rarely setting foot on the land.

$899

Complete per person, double occupancy plus $30.00 tax and services

Here's What's Included! • Jet flights all the way • accommodations at luxurious hotels • Full American breakfasts each day at your hotel • Dinners at your hotels or at a choice of top restaurants from a list provided • Transfers for you and your luggage (2 pieces not exceeding 44 lbs.) to and from each airport and hotel • Sightseeing tour in each city you visit • Briefings in each city, with experienced Oriental Carnival staff to assist you and tour escort all the way • All meal tips in Tokyo, Taipei and Hong Kong • Tips for luggage transfer in all 3 cities • Special Oriental Carnival optional tours. And there is ABSOLUTELY NO REGIMENTATION. Your time is your own in each city to enjoy your Carnival vacation as you like at your own pace

DEPARTURE DATE: AUGUST 7, 1969/DEPARTURE POINT: BIRMINGHAM

JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA EC
9 SO. JACKSON ST./MONTGOMERY, ALA. 36104 (205) 263-6441

Gentlemen Enclosed please find $ _____ as deposit ☐ as full payment in full ☐. (Make Check or money order payable to THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA $100 minimum deposit per person. Final payment due 30 days before departure.)

NAME _____ PHONE _____

STREET _____

CITY _____ STATE _____ ZIP _____

DEPARTURE CITY _____ DEPARTURE DATE _____

Return this reservation immediately to insure space Reservations limited Rates based on double occupancy Single rate $100 additional Special rates for children under 12 upon request

© Copyright 1968, AITS Inc

Days Of VD In Alabama Are Numbered, Dr. "Why" Smith Declares

Four hundred and eighty years after the crew of Columbus carried back across the Atlantic the American Indian's most terrible gift to the world, Alabama will be completely free of syphilis.

This confident prediction for 1972 is made by Dr. Walton Harold Young Smith, whose initials in themselves have been a challenging question standing before the citizens of Alabama for 35 years. Dr. Smith came to Alabama Sept. 15, 1934, at the insistence of the then State Health Officer, the late Dr. James Norment Baker, to direct the continuing war on venereal disease. This remained Dr. "Why" Smith's pet project, even after he became director of the entire Division of Communicable Diseases, State Health Department.



Dr. W. H. Y. Smith

In the early days of the 20th century, Canada was seeking to channel its school children's education in the way they chose to go in mature life. When, at the age of 13, young Smith announced he intended studying medicine, Latin immediately became a required course. He is proud of the fact that his medical degree is from McGill University ("the greatest school in Canada") and his Master's from Johns Hopkins ("then the greatest in the United States").

Married in Cedar Rapids, Iowa, to Ona Edith Jakelin, they discovered together the paradise that is the Deep South, and their removal to Montgomery was preceded by several years in Florida, in private practice and public health work.

Nine years after arriving in Montgomery, in 1943, Dr. Smith launched one of the most ambitious wars on venereal disease in this nation's history. It developed into a five-year plan, in which time every Alabamian between the ages of 15 and 50 (more than 1,400,000 of them) was blood-tested and the infected started on a compulsory treatment course.

That program had accomplished its primary objectives by 1948, and since that time Dr. Smith has operated with a field force, a sort of commando army used to "blitz" infected areas in the state, wherever they developed. This field force still functions effectively, under the direction of Mr. John Hill, with whose family Dr. Smith is temporarily making his home, recuperating from a massive heart attack.

Mrs. Smith died several years ago and their son, Walton Michael Smith, choosing photography for his life's profession, married and moved East.

The year 1969 has proved disastrous physically for Dr. "Why" Smith. In January, attending a medical meeting in Mobile, he slipped and fractured two vertebra in his back. Recovered enough to move about in braces, he collapsed with a coronary thrombosis.

But he is cheerful about it all and, while retired as director of this division of the Health Department, fully expects to return to active duty in the next few months—"wherever I'm needed."

"Shall I order Maalox?"





"Yes. Patients respond well to it, and seem to take it more faithfully."

Works well · Doesn't constipate · Tastes good · Economical

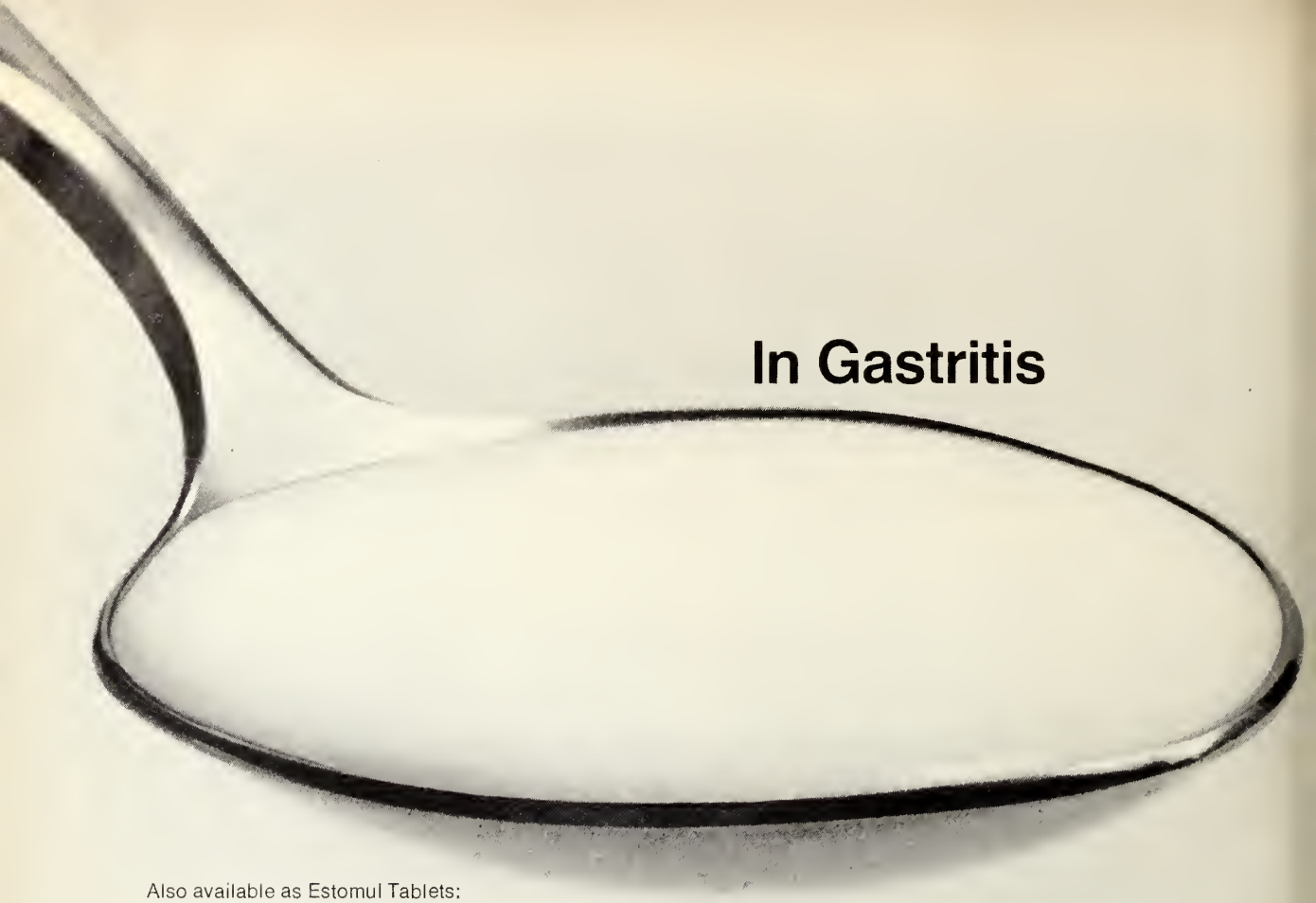
Supplied: Maalox Suspension (12 fl. oz.). *Also available:* Maalox No. 1 Tablets (0.4 Gm.) : no sugar, low sodium content. Maalox No. 2 Tablets (0.8 Gm.) : double strength for double antacid action.

THE NUMBER ONE ANTACID

Maalox®

MAGNESIUM-ALUMINUM HYDROXIDE

WILLIAM H. RORER, INC.
Fort Washington, Pa. 19034



In Gastritis

anticholinergic
antacid
demulcent
topical anesthetic

it's all here!

Estomul®
Liquid

Each tablespoon (15 cc.) contains:
orphenadrine HCl, 25 mg.;
bismuth aluminate, 50 mg.;
aluminum hydroxide—magnesium carbonate
(as co-precipitate), 918 mg.

Also available as Estomul Tablets:

Each swallow tablet contains: orphenadrine hydrochloride, 25 mg.; bismuth aluminate, 25 mg.; magnesium oxide, 45 mg.; aluminum hydroxide-magnesium carbonate (as co-precipitate), 500 mg.

Indications: Peptic ulcer: duodenal, marginal, gastric, esophageal; gastroesophageal reflux; esophagitis (without stricture); irritable bowel syndrome; hyperacidity and dyspepsia; congenital shortening of esophagus with esophagitis; heartburn; spasm of the cardiac end of esophagus; gastritis; symptomatic hiatus hernia; alcoholic gastritis; functional pylorospasm.

Contraindications: Because of the anticholinergic action of orphenadrine, Estomul should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcers, prostatic hypertrophy or obstruction at the bladder neck, achalasia (megaesophagus), and myasthenia gravis.

Precautions: Doses in excess of six tablets or six tablespoons of liquid daily may produce minor side actions such as dryness of the mouth or blurred vision.

Warning: Use of any drug in pregnancy, lactation or in women of child-bearing age requires that the potential benefit of the drug be weighed against its possible hazards to the mother and child. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Side Effects: Possible side actions include: tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, an elderly patient may experience some degree of mental confusion.

Dosage: For adults: One or two tablespoons of liquid or one or two swallow tablets three times daily; depending on severity.

Availability: On Rx only. 12 oz. bottles of liquid and bottles of 100 swallow tablets.

Riker Laboratories • Northridge, California 91324

The Riker Representatives in your area are: Bob Johnson, Bill Phillips, Bill Crabb

Fractured Elbows As Seen By An Alabama Orthopodist

It is hard to imagine a more effective use of color than is sometimes found in medical books and magazines. One of the most recent examples is the series used in the current *Clinical Symposia* to illustrate an article on *Injuries to the Elbow* by H. Earle Conwell, M. D., F. A. C. S.



Dr. H. E. Conwell

The illustrator is Dr. Harold Walton, the famous M. D. anatomical artist, recognized as the best in the United States and possibly the world.

Dr. Conwell was born in Walker County, Alabama, in the town of Oakman in 1893. Twenty-two years later he was graduated from the University of Alabama with a Medical degree. In World War I he served overseas from 1917 to 1919, a captain in the Medical Corps of the Army, and in World War II he served as Orthopaedic Consultant for the Fourth Corps Area.

He is a great, great-nephew of the late Dr. Russell H. Conwell of Philadelphia, lawyer, Baptist minister, founder and first president of Temple University, remembered to this day for his lecture, "Acres of Diamonds," which he delivered 6,000 times.

Dr. Earle Conwell, medical school professor, textbook author, limits his practice through the Conwell Orthopaedic Clinic in Birmingham, to fractures and orthopaedic surgery.

His stepson, Perry O. Hooper, an attorney, is probate judge of Montgomery County, married to the former Marilyn Yost of Montgomery, daughter of Mrs. Walter J. Yost and the late Mr. Yost, and their sons are: Perry Hooper, Jr., Walter Yost Hooper, Earle Conwell Hooper, and John Wyatt Hooper.

The essay, "Injuries to the Elbow," is a chapter from the internationally known textbook, Key and Conwell's *Management of Fractures, Dislocations, and Sprains*, the 7th edition of which was published in 1961.

A member of the Board of American Orthopaedic Surgery, a Diplomate of that Board, Dr. Conwell is also a member of MASA, AMA, AOA, SMA, the Southern and Southeastern Surgical Societies, the American College of Surgeons, and the American Academy of Orthopaedic Surgeons.

Dr. R. B. Solves of the University of Southern California, medical researcher, says he has solved the mystery of pre-determining the sex of the unborn child. He samples the fluid in which the fetus rests in the womb, and insists his findings are 100 per cent correct as much as six months in advance of birth.

Internist and General Practitioner needed in growing North Central Alabama town of 45,000 on Tennessee River. Well diversified industry. Excellent schools. Associate with two physicians with established practice. New office space available two blocks from accredited hospital.

Contact
R. M. MILLER, SR., M. D.
1107 16th Ave., S. E.
Decatur, Alabama 35601



Alabama's new Blue Shield URC plan delivers payment of physicians' fees under controls derived from the medical profession itself.

BLUE CROSS-BLUE SHIELD OF ALABAMA



introducing alginates to antacids

for a difference in taste you can feel

Derived from seaweed, and long used to impart velvety consistency to foods, alginates—a Warner-Chilcott contribution to antacid palatability—help 1) erase the chalkiness and grittiness found with some other antacids; 2) dispel unpleasant aftertaste. Like ice cream, Gelusil-M is smooth and creamy; and it has a cool mint flavor. Thus, for your patients Gelusil-M is excellent to start on and easy to stay on.

introducing

GELUSIL®-M

NEW

each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate
250 mg. aluminum hydroxide (Warner-Chilcott)
200 mg. magnesium hydroxide

*U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

†Avoids constipation.

See next page for prescribing information ▶

GELUSIL–one name to remember...and a dosage form for every patient.



Gelusil®-M Liquid

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquid

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)—or more—between meals and at bedtime, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey
GM-IN-91-4C

Books Of Professional Interest

MEDICAL CORPS HEROES OF WORLD WAR II, by Wyatt Blassingame, Random House, New York, 185 pages including photographs—$2.95.

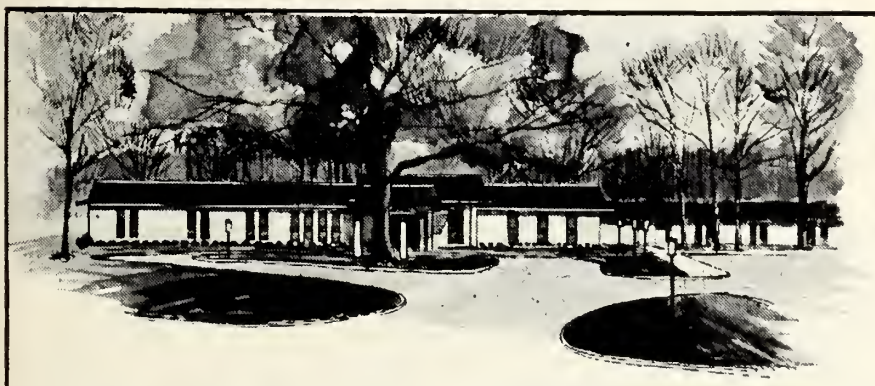
A native of Tuscaloosa, son of a member of the teaching staff of the University of Alabama, himself a graduate, Wyatt Blassingame went from the reportorial staff of The Montgomery Advertiser to New York, three decades ago, to become a successful freelance writer of fact and fiction.

Much of the content of this book is from information obtained first hand, as Blassingame served as an intelligence officer with the Naval Air Corps on the islands of Tinian and Okinawa, also observing the work of medical corpsmen and doctors when he visited sick and wounded comrades in hospitals on Hawaii, Saipan, and Okinawa.

Beginning with Pearl Harbor, Wake, and the Philippines, the book moves through Guadalcanal, the Solomons, the Gilberts and other Pacific islands, around the world to the Anzio Beachhead, D-Day, Germany's Western front, on to Army and Navy Medics at sea, and finally back to Iwo Jima and Okinawa.

Written primarily for young readers, in the famous Landmark Series, it is a book for the whole family, of very special interest to the doctor's family.

—M.



THE BRADLEY CENTER

An all new homelike psychiatric residence located on a lovely five-acre tract inside the city, providing a comprehensive range of services, including inpatient (28 beds), day care, and outpatient treatment. The therapeutic setting is an open community one with no provisions for locked wards. Each patient participates in an intensive treatment program consisting of individual pyschotherapy, group psychotherapy, topical small group discussions, occupational therapy and recreational therapy, and other group activities in the Center as well as in the community, depending on individual interests and needs. Drugs are used when appropriate.

Any individual may be admitted who, in the opinion of the staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible member of his family.

Brochures and rate schedules are available on request.

Leonard T. Maholick, M. D.
Medical Director

Maj. Gen.(Ret.) Howard Snyder
Administrator

THE BRADLEY CENTER, INC.
2000 Sixteenth Avenue
Columbus, Georgia 31901
Area Code 404 - 324-4882

INDEX TO ADVERTISERS

Blue Cross-Blue Shield 104
The Bradley Center 107
Bristol Laboratories ..... 3rd Cover
Burroughs Wellcome 96

Campbell Soup 47
Classified 103

Eaton Laboratories 7

Geigy Pharmaceuticals 54, 55, 56, 59, 74, 75
Glenbrook Laboratories 62
Guest House 70

Highland Hospital 8
Hynson, Westcott & Dunning 1

Lederle Laboratories 3, 15, 16, 17, 20, 83, 108
Eli Lilly & Company ..... 1st Cover, 28

McNeil Laboratories, Inc. 84

National Drug Co. ..... 2nd Cover, 11, 12

Parke, Davis & Co. 50

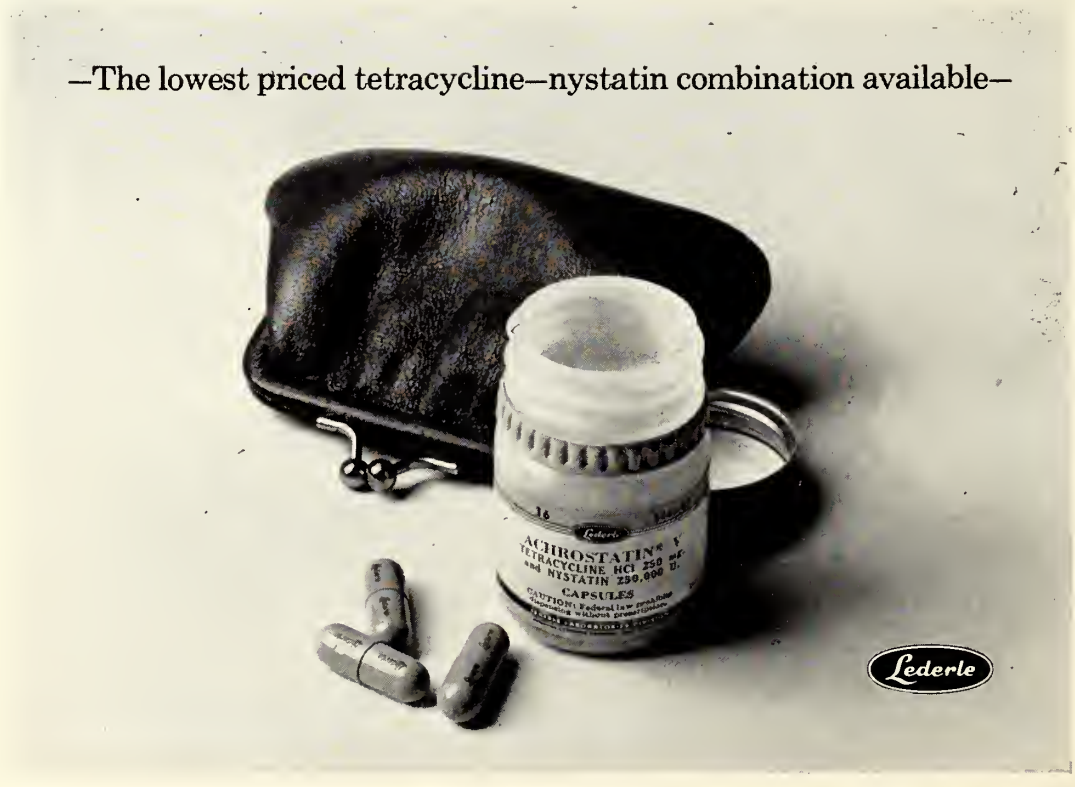
Riker Laboratories 26, 27, 90, 91, 102
A. H. Robins Co., Inc. 64, 65, 66, 67, 68, 69, 87
Roche Laboratories ..... 60, 61, 78, 79, 93, 94, 95, 4th Cover
Wm. H. Rorer 101

Sandoz Pharmaceuticals 81
G. D. Searle & Co. 48, 49
Smith Kline & French Labs. 5, 53

V. A. Hospital 8

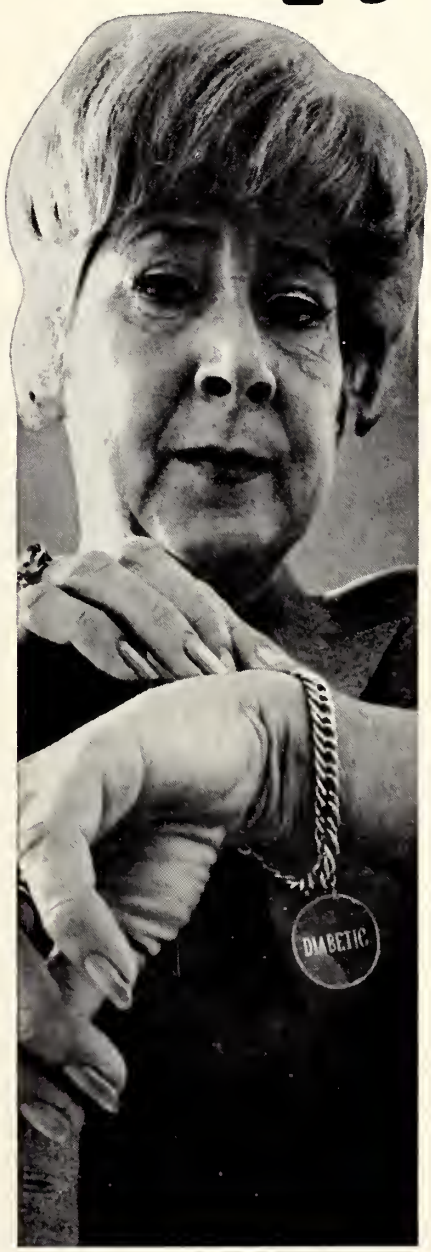
Warner Chilcott 71, 72, 105, 106
Winthrop Labs. 82
Wyeth Labs. 21, 22, 77

—The lowest priced tetracycline—nystatin combination available—



a broad-spectrum antibiotic for the diabetic:

threat or therapy?



Disordered metabolism makes her prone to bacterial infection —and to moniliasis.

When she needs tetracycline, she may also need protection against the threat of fungal overgrowth. And Tetrex-F can provide both.

Each capsule contains 250 mg. of tetracycline phosphate complex to control sensitive bacterial pathogens...and nystatin, 250,000 units, as a precautionary measure against troublesome vaginitis, proctitis or other monilial infections. However, superinfection with other, nonsusceptible organisms may occur.

Tetrex-F®

(tetracycline phosphate complex-nystatin)

PRESCRIBING INFORMATION: Tet-F. 5—2/23/67. For complete information consult Official Package Circular.

Indications: Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections.

Contraindications: The drug is contraindicated in patients hypersensitive to its components.

Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).

Precautions: Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months.

Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.

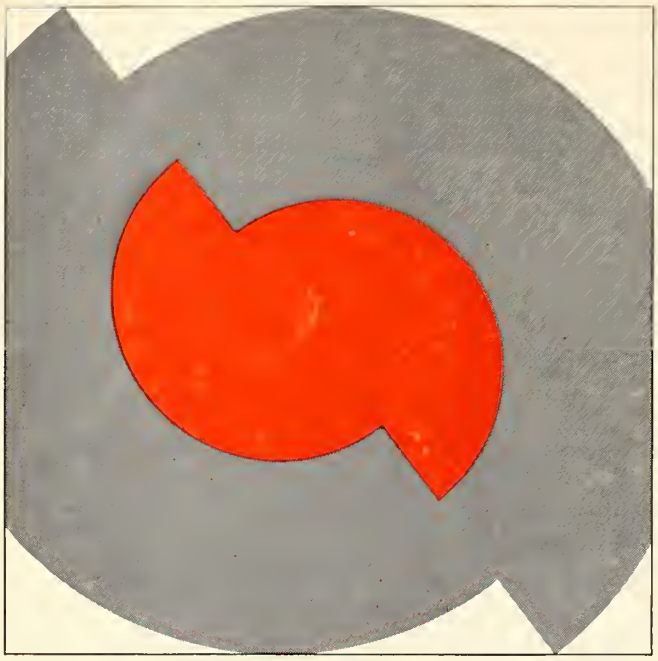
Usual Adult Dosage: 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.

Supplied: Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin.

For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles. **A.H.F.S. Category 8:12**

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



from the discord of anxiety...



to emotional harmony

with the aid of antianxiety

Librium®
(chlordiazepoxide HCl)
5-mg, 10-mg and 25-mg capsules

In an age of swift change and challenge, susceptible individuals may experience varying degrees of excessive anxiety. The resulting emotional stress may precipitate significant functional disorders or complicate existing organic disease. In properly individualized maintenance dosage, Librium (chlordiazepoxide HCl) quickly helps relieve anxiety and apprehension, provides useful adjunctive therapy in psychophysiologic disorders—yet seldom impairs mental acuity or ability to function. Librium has demonstrated a wide margin of safety in short- and long-term therapy.

Also available:
Libritabs®
(chlordiazepoxide)

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

JOURNAL of the Medical Association of the State of ALABAMA

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON
7 AUG 1969

IN THIS ISSUE

Renal Angiomyolipomas: Report of Two Cases and Review 141

The Psychologist as the Psychiatrist's Pathologist - A Rebuttal 150

HOPE "Virus" Infects Everyone Who Goes Aboard 170

Write it any way you please

Cordran®

Flurandrenolone



Cream Cordran contains flurandrenolone, 0.05 percent, stearic acid, cetyl alcohol, mineral oil, polyoxyl 40 stearate, ethylparaben, glycerin, and purified water.

Lilly

Additional information available upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

900415

AUGUST 1969



Dear Doctor, You made me what I am today - a whole lot slimmer!

TEPANIL—the right start in support of the weight-control program *you* recommend. It reduces the appetite. Doesn't kill it. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation. Because TEPANIL works on the appetite, not on the "nerves."

Contraindications: Cancurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally sofer than the amphetamines use with great caution in potients with severe hypertension or severe cardiovoscular disease. Da not use during first trimester of pregnancy unless potential benefits autweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuotion of therapy, unpleosont symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence.

As is characteristic of sympathomimetic agents, it may occasianally cause CNS effects such as insamnia, nervausness, dizziness, anxiety, and jitteriness. In contrast, CNS depressian has been reported. In a few epileptics an increase in canvulsive episades has been reported.

Sympathomimetic cardiavascular effects reparted include anes such as tachycordia, precordial poin, arrhythmia, palpitation, and increased blaad pressure. One published report describes T-wave changes in the ECG af a healthy yaung male after ingestion of diethylpropian hydrochloride; this was an isolated experience, which has not been reparted by athers.

Allergic phenomeno reported include such canditions as rash, urticaria, ecchymosis, and erythema. *Gostrointestinal effects* such os diarrhea, constipatian, nausea, vamiting, ond abdominal discomfort hove been reported.

Specific reparts on the hematapoietic system include two each of bone marrow depression, agronulocytosis, ond leukopenio.

A variety af miscellaneous adverse reactians have been reported by physicians. These include complaints such os dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, ond polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one haur before meals. If desired, on additional tablet may be given in midevening ta overcome night hunger. Use in children under 12 yeors of age is nat recammended.

Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride)

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144 T-91BA U.S. PATENT NO. 3,001,910 5/69

Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

N THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF REMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

LUTREXIN, the non-steroid "uterine elaxing factor" has been found to be useful y many clinicians in controlling abnormal terine activity.

Literature on indications and dosage avail-ble on request.

- No side effects have been reported, even when massive doses (25 tablets per day) were administered.
- Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. BALTIMORE, MARYLAND 21201

(LTR23)

THE JOURNAL

of the

Medical Association of the State of Alabama

Volume 39 • August, 1969 • No. 2

Office of Publication
19 So. Jackson St. — Montgomery, Ala. 36104
Subscription Price — $5.00 Per Year
$1.00 Per Copy

Second Class Postage Paid at Montgomery, Alabama. Published monthly in Montgomery at 19 South Jackson Street.

Editor-in-Chief
William L. Smith, M. D. — Montgomery

Managing Editor
L. P. Patterson — Montgomery

Assistant Managing Editor
Mary Nell Williford — Montgomery

Associate Editors
J. P. Collier, M. D. — Tuscaloosa
John M. Chenault, M. D. — Decatur
M. Vaun Adams, M. D. — Mobile

Officers of the Association

President
C. Kermit Pitt, M. D. — Decatur

President-Elect
S. Buford Word, M. D. — Birmingham

Vice-Presidents
F. M. Phillippi, Jr., M. D. — Brewton
J. E. Cameron, M. D. — Alexander City
O. Emfinger, M. D. — Union Springs
Wood S. Herren, M. D. — Birmingham

Secretary-Treasurer
William L. Smith, M. D. — Montgomery

Executive Director
L. P. Patterson — Montgomery

The State Board of Censors
John M. Chenault, M. D., Chmn. — Decatur
J. P. Collier, M. D. — Tuscaloosa
Hugh E. Gray, M. D. — Anniston
Paul W. Burleson, M. D. — Birmingham
L. L. Hill, M. D. — Montgomery
M. Vaun Adams, M. D. — Mobile
J. D. Bush, M. D. — Gadsden
E. L. Strandell, M. D. — Brewton
John W. Davis, Jr., M. D. — Montgomery
J. Garber Galbraith, M. D. — Birmingham

State Health Officer
Ira L. Myers, M. D. — Montgomery

Delegates and Alternates to the American Medical Association

(Terms expiring December 31 of year shown.)

1970
Delegate—E. Bryce Robinson, Jr., M. D., — Fairfield
Alternate—W. E. White — Anniston

1971
Delegate—M. Vaun Adams, M. D. — Mobile
Alternate—E. L. McCafferty, Jr., M. D. — Mobile
Delegate—P. W. Burleson, M. D. — Birmingham
Alternate—Robert Parker, M. D. — Montgomery

CONTENTS

President's Page — 112

The Woman's Auxiliary — 114

Editorial Comment — 123

- Years Revise Attitude Toward Strikes Against The Public Health and Welfare — 123
- Voluntary Sterilization Offers Simple Cut For Population Explosion — 124
- It's All Of A Pattern With Campus Unrest And Postponed Maturity — 126
- There's A Difference — 126
- Span of Adolescent Years Doubled—And Youth Crisis Became Inevitable — 129

MASA President And Hero In War On Yellow Fever — 130

Decorated Combat Flier Becomes MASA and ALAPAC Leader — 137

Scientific Section — 141

- Renal Angiomyolipomas: Report of Two Cases and Review, Henry C. Hudson, M. D., George F. Scofield, M. D., Rube Hundley, M. D., William Gates, Jr., M. D., Birmingham — 141
- The Psychologist as the Psychiatrist's Pathologist—A Rebuttal, A. Jack Turner, Ph. D., and T. J. Michels, Ph. D., Auburn, Alabama — 150

Association Forum — 157

- Drs. Wilbur and Rogers Differ On Future Of Medicine — 157
- Mrs. Chenault Becomes Auxiliary President On Epic Date In History — 163

HOPE "Virus" Infects Everyone Who Goes Aboard—Esprit De Corps, William A. Daniel, Jr., M. D., Birmingham — 170

Around the State — 178

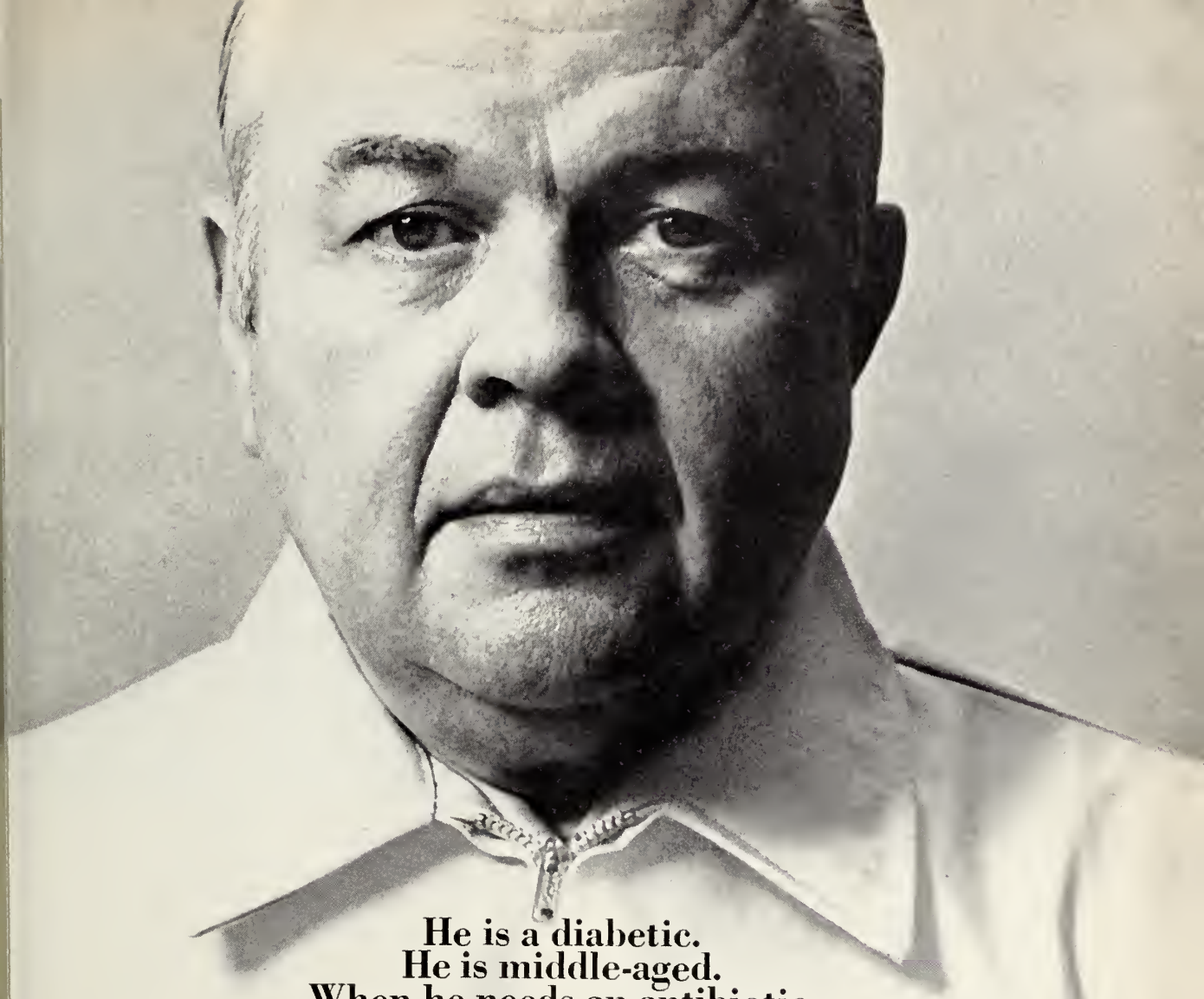
- Vital Statistics — 178
- Dead At 96, Dr. Harris Leaves Two Sons In Active Medical Practice — 180

Alabama Department of Public Health — 182

- Mobile County—A Child Centered Program To Prevent Tuberculosis — 183

The Month in Washington — 187

Physician Placement Service in Alabama — 192



He is a diabetic.
He is middle-aged.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

uard susceptible patients against intestinal monilial over-th during broad-spectrum therapy—the protection of statin is combined with demethylchlortetracycline in LOSTATIN.

or your susceptible candidates, prescribe DECLOSTATIN e broad-spectrum therapy that prevents monilial growth.

tiveness: Because its antibacterial component is DECLOMYCIN thylchlortetracycline, DECLOSTATIN should be equally or more ive therapeutically than other tetracyclines in infections caused by ycline-sensitive organisms. The antifungal component, Nystatin, ts against superinfection by antibiotic-resistant fungal overgrowth icularly monilia) in the intestinal tract.

aindication: History of hypersensitivity to demethylchlortetracy- or nystatin.

ning: In renal impairment, usual doses may lead to excessive accum- n and liver toxicity. Under such conditions, lower than usual doses dicated, and, if therapy is prolonged, serum level determinations e advisable. A photodynamic reaction to natural or artificial sun- has been observed. Small amounts of drug and short exposure may ce an exaggerated sunburn reaction which may range from ery- to severe skin manifestations. In a smaller proportion, photo- ic reactions have been reported. Patients should avoid direct ure to sunlight and discontinue drug at the first evidence of skin nfort. Necessary subsequent courses of treatment with tetracy- should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

President's Page



C. Kermit Pitt

The Medical Association of the State of Alabama salutes Mrs. John M. (Belle) Chenault, President of the Woman's Auxiliary to the American Medical Association.

A woman of many talents and much wisdom, Belle presides over a lovely home where hospitality spontaneously and forever flows. Her success as a mother is attested by five delightful children. As the wife of John, Chairman of the State Board of Censors and Trustee of the American Medical Association, she has even made some progress toward the civilization of man. Her civic, religious and medical accomplishments are legion. They encompass the following activities: Girl Scouts (past council president), D. A. R., Colonial Dames of the 17th Century, Garden Club of Alabama, Decatur Mothers Club, League of Women Voters, Women's Chamber of Commerce, PTA, County Mental Health Association, Red Cross, the American Association of University Women, Baptist Church, Southern Medical Association Auxiliary (past president), Woman's Auxiliary to the American Medical Association (by-laws chairman, 1st vice president, historian director and president elect). She has served the state and county medical auxiliaries in many capacities.

A native of Alabama, Belle grew up in Tuscaloosa, graduated from Tuscaloosa schools, including the University of Alabama where she attained all the honors (Phi Beta Kappa, Kappa Delta Pi, Alpha Lambda Delta, Mortar Board and Zeta Phi Eta professional speech sorority). Since her husband, Dr. John Chenault, completed his tour of duty with the World War II Armed Services they have lived in John's home town, Decatur.

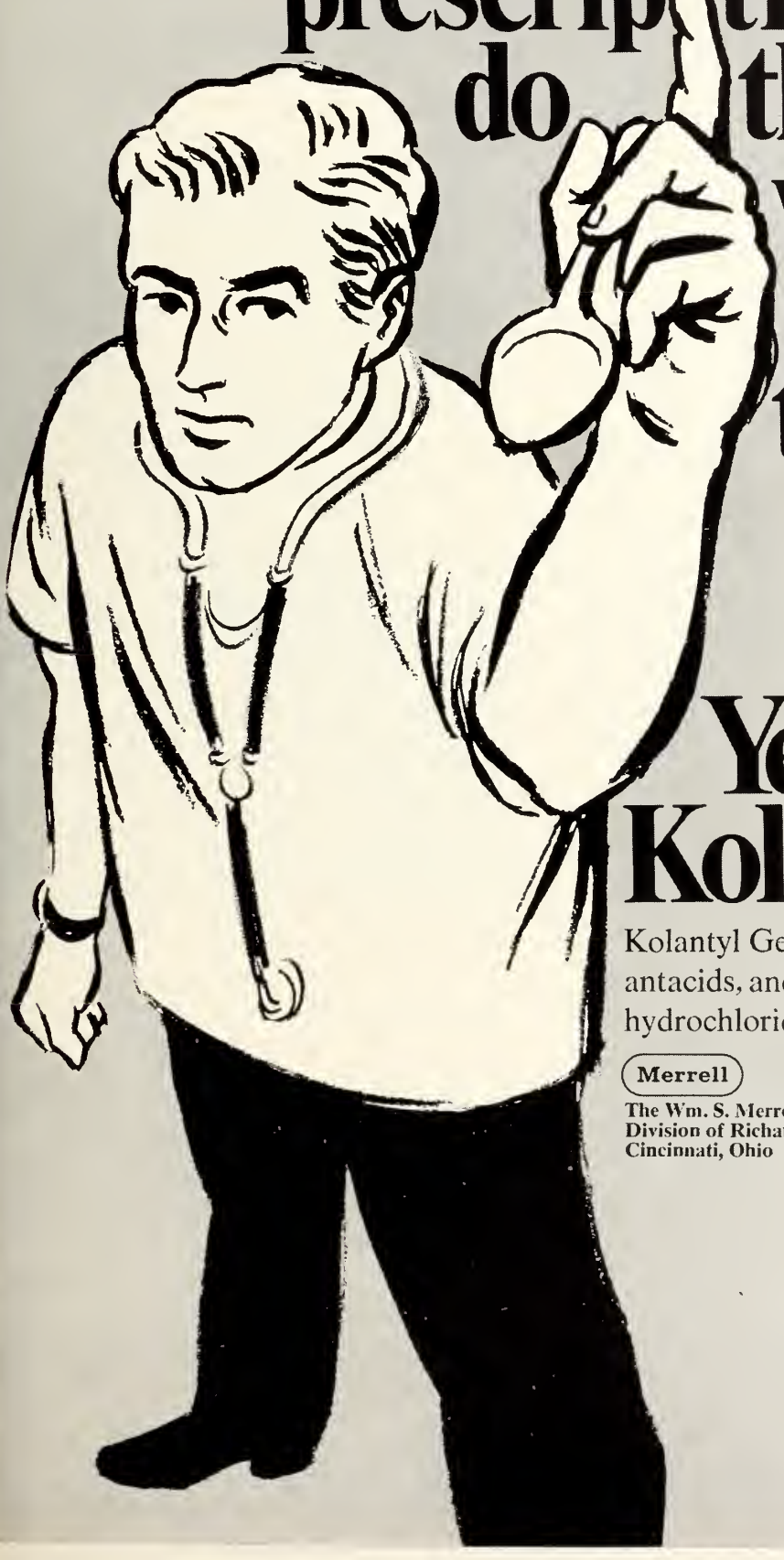
As the president of the Medical Association of the State of Alabama and as your long time personal friend, Belle, I use the privilege of this page to express my pride in you and my appreciation and love for you. You reflect great credit upon your family, your friends, your city, your state and your nation.

Your administration of the affairs of the Woman's Auxiliary of the American Medical Association will favorably influence the action of that great organization for years to come.

Proudly we salute Belle Chenault, President of the Woman's Auxiliary to the American Medical Association.

C. Kermit Pitt, M. D.

Can one prescription do the work of two?



Yes, Kolantyl®.

Kolantyl Gel/Wafers contain antacids, and Bentyl® (dicyclomine hydrochloride) too.

Merrell

The Wm. S. Merrell Company
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215

(0715)

The Woman's Auxiliary

President, Mrs. Ben H. Johnson, Jr.
President-Elect, Mrs. Howard C. Johnson
Northeast District Vice President, Mrs. James D. Holliman, Jr.
Northwest District Vice President, Mrs. Gene Qualls
Southeast District Vice President, Mrs. George Andrews
Southwest District Vice President, Mrs. Andrew D. Henderson
WAMASA Editor, Mrs. William L. Smith

AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the Medical Association of the State of Alabama. I will support its activities, protect its reputation and ever sustain its high ideals."

As I am writing this, the "good ole summer time," is going full blast and the heat continues. However, this is the time of planning for next year's Auxiliary work, and to keep the funds for AMA-ERF coming in. Auxiliary work has been going on since the Convention in Huntsville, and you are responding so well to our pleas for contributions to the AMA-ERF AUXILIARY FUND.

Mrs. Richard A. Dillard, 3631 Locksley Drive, Birmingham 35223, reports that many doctors have sent in their donations through the Auxiliary Fund, that she receives money every day. Our special thanks to doctors who send in contributions from counties where we do not have an organized Auxiliary. This makes us feel that we are getting the message to all of you of the importance of this fund.

To better understand how important our money is to our own medical college I wish to quote a portion of a letter recently received from Dr. Clifton K. Meador, Dean of the Medical College of Alabama.

"I thought you might want to relay the information to the members of the Auxiliary that we are beginning the Telephone Information Service with these funds. This service will be available eventually to all the physicians in the State who have questions they might want answered concerning their patients. We will tie to this the Xeroxing service for certain specific articles from the literature the physicians might need in their practice. We will begin this program on a limited basis in four counties for six months to work out all the kinks, and if the program is successful in these four counties and can work smoothly, we will open it to all the State physicians. It is only with funds such as AMA-ERF that we are able to try innovative and new programs, particularly in the area of continuing education. Again, I want to thank you and all the members of the Auxiliary for your continued generous support."



Mrs. Ben H. Johnson

Conventions just don't happen, they are planned a year or more in advance and much preparation goes into a good one. As you know the convention of the Medical Associa-

(Continued on Page 115)

The Woman's Auxiliary

(Continued from Page 114)

tion and that of the Medical Auxiliary are held on the same date and this has proved to be a great plan to get the doctor and his wife to combine business and pleasure. So, since planning has already begun for the Convention in Mobile in 1970, just keep in the back of your mind that on April 30 to May 2, you and your wife should be on hand for a really great convention. The plans are exciting and every effort is being made by the committee of doctors and the Auxiliary committee to insure that you both will have a good time and at the same time become informed on up to the minute happenings in medicine, in the health field, and a little dose of politics for good measure.

Mobile is a gracious and charming place, the motel and hotel accommodations are excellent and all within walking distance of the auditorium. Make your wife happy at this summer's end time of the doldrums and tell her that you have already had your Secretary mark you out of the office for these dates—and do it today.

Ruth L. Johnson

(Mrs. Ben H. Johnson, Jr.)
President, WAMASA

Internist and General Practitioner needed in growing North Central Alabama town of 45,000 on Tennessee River. Well diversified industry. Excellent schools. Associate with two physicians with established practice. New office space available two blocks from accredited hospital.

Contact
R. M. MILLER, SR., M. D.
1107 16th Ave., S. E.
Decatur, Alabama 35601



You can give a better ear exam EASIER with the new Hotchkiss™ Otoscope

A radical advance in otoscope design, the Hotchkiss employs the principles of modern optics to give you a brighter, clearer, more informative view of the ear canal and tympanic membrane. It weighs just five ounces (including batteries) and fits into your shirt or jacket pocket. You can carry it anywhere; use it repeatedly without fatigue. And the Hotchkiss is built to stand up to far rougher treatment than you're likely to give it.

See for yourself. Clip and mail the coupon, and our Representative will call for an appointment to show you the new Hotchkiss Otoscope in your office.

SK&F **Smith Kline & French Laboratories**

Smith Kline & French Laboratories E-30 A
1500 Spring Garden Street
Philadelphia, Pa. 19101

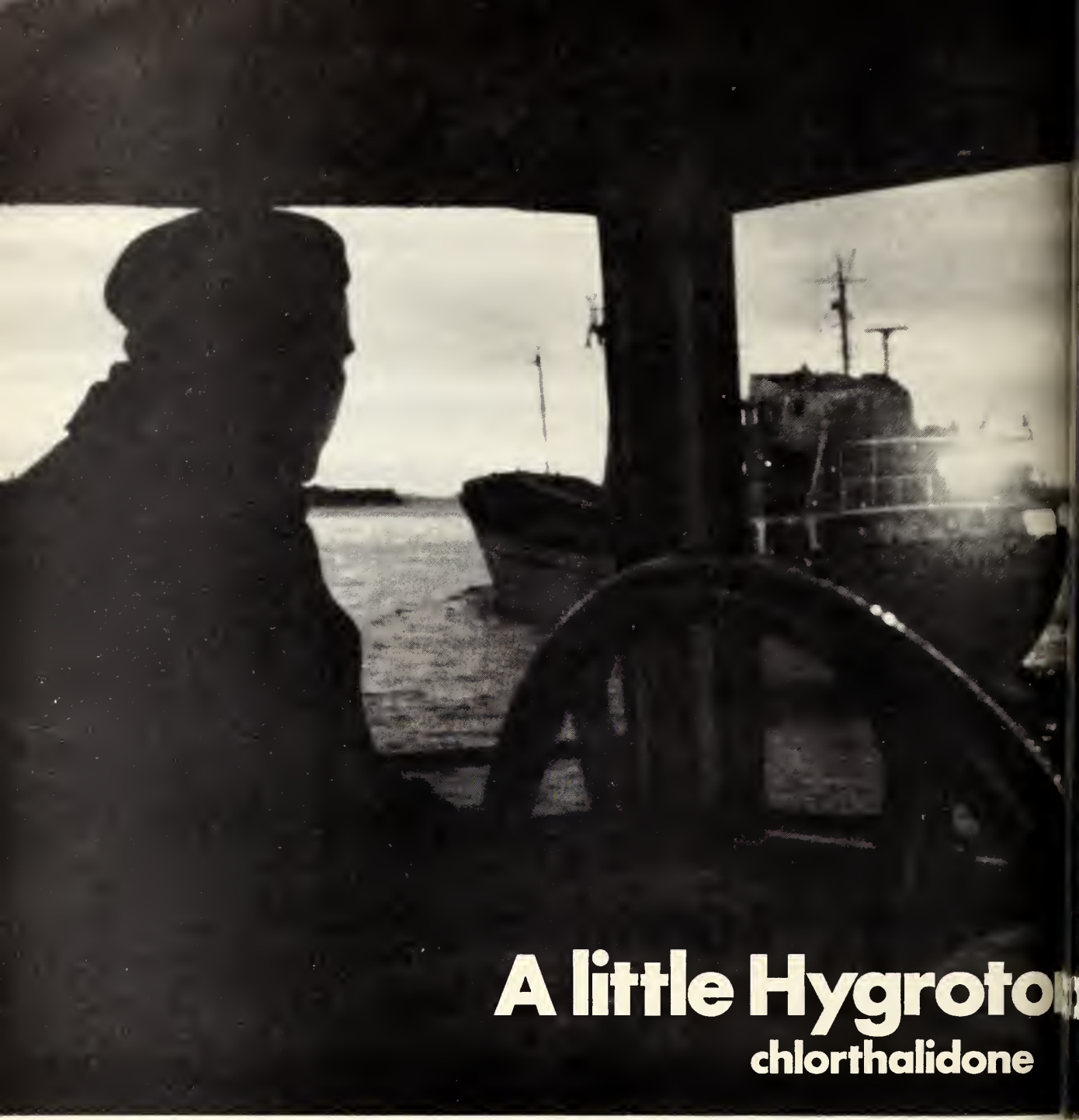
I would like your Representative to call for an appointment to show me the Hotchkiss Otoscope.

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

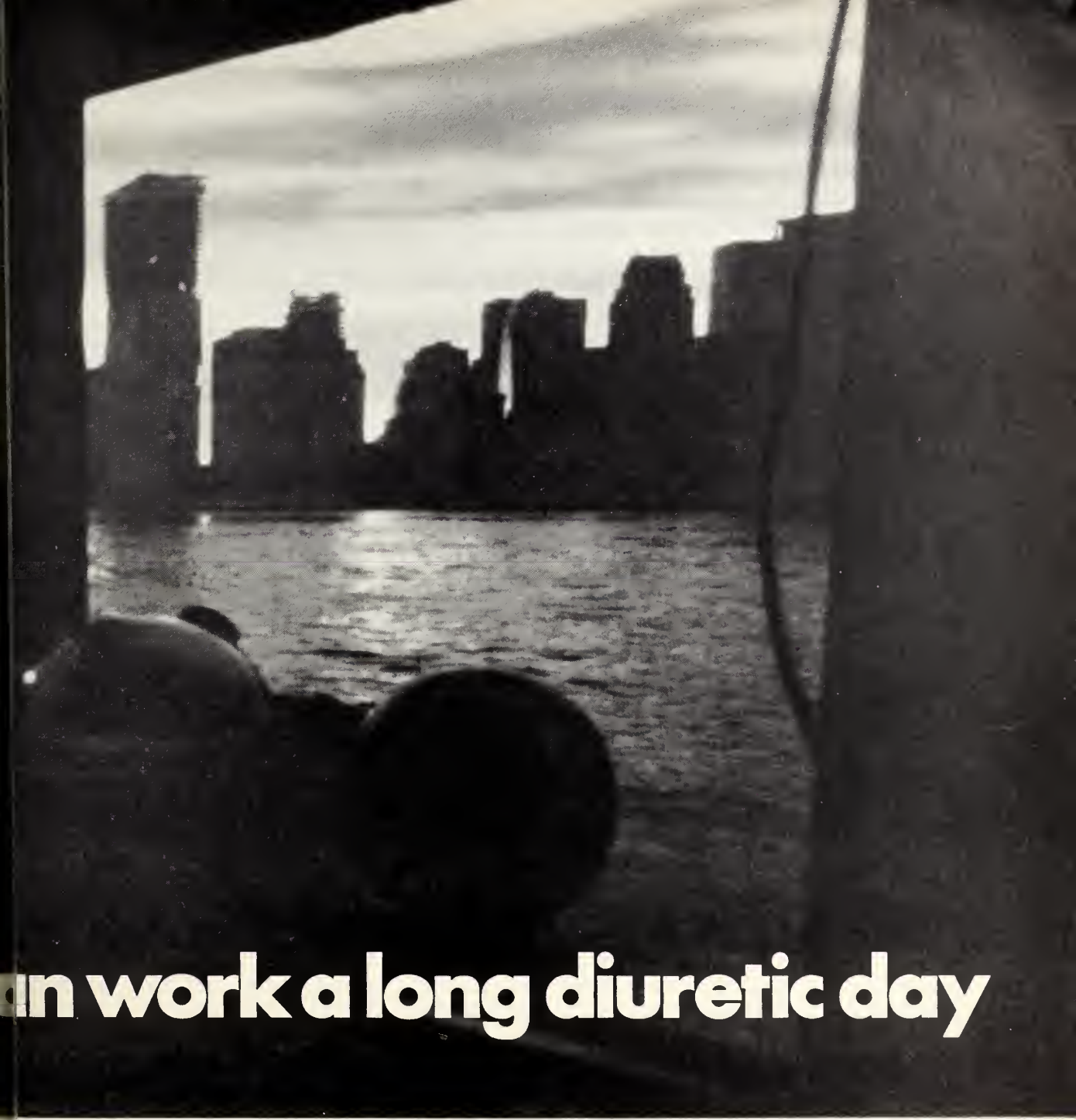
☐ Send descriptive literature



A little Hygroto

chlorthalidone

HY-6674



n work a long diuretic day

tle way from one daily tablet to the next
elp control edema and hypertension

onged action usually provides smooth, sustained diuretic
veness; real one-a-day dosage, right from the start; convenience
onomy.

ton, chlorthalidone, can cause side effects. And it's contra-
ed in hypersensitivity to the drug and severe renal and
c diseases.

the prescribing information. It's summarized on the next page.

Geigy



A little Hygroton® can work a long diuretic day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepotic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal poin, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental borrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympothectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepotic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in potients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipotion and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and poncreatitis when epigastric poin or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)46-230-E

For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

HY-6674

Because any urologic infection can be serious, **BREON** introduces potent therapy

for the strong start and a fast finish...

"...a significant gap appears to have been closed in the armory of drugs available to the urologist."[1]
Bacteriuria and symptoms can be eliminated within 48 to 72 hours; susceptible infection often in 10 to 14 days.

before your "minor" becomes a major problem

choice initial treatment for urinary infections

Cybis® (nalidixic acid) provides prompt broad gram-negative bactericidal activity at normal urinary pH range that can eradicate troublesome *E. coli,* Aerobacter and Proteus. A good starting drug, it can effectively accelerate management of infection due to sensitive organisms.

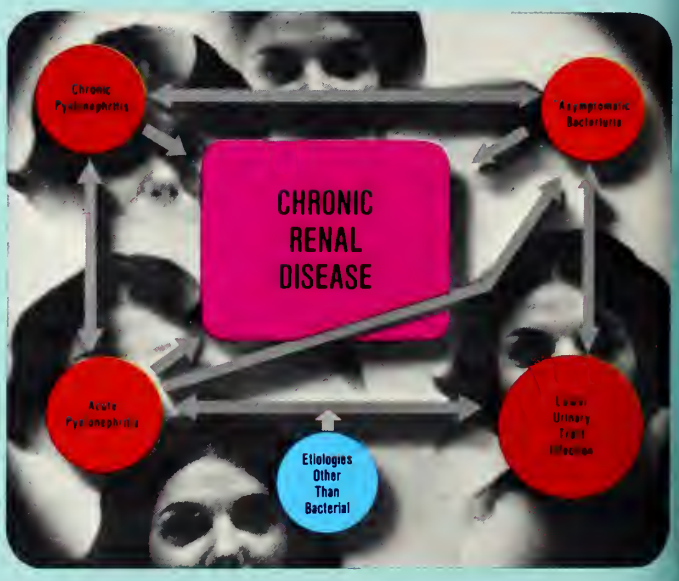
essential control within the primary 72-hour cycle

In cases of acute infection due to susceptible organisms, Cybis works well toward the rapid clearing of disease when obstruction is absent or can be relieved. Within 48 to 72 hours, symptoms are frequently eased and bacteriuria eliminated. Susceptible infection is often eradicated in 10 to 14 days.

blocks the young female progression of infection

Cybis can be useful in naturally susceptible young female patients with new or well-established urinary disturbances. Combining rapid potency with relative freedom of serious side reactions and toxicity, the drug can be of particular value in preventing higher tract involvement or blocking the possible continuum of disease. (See Chart)

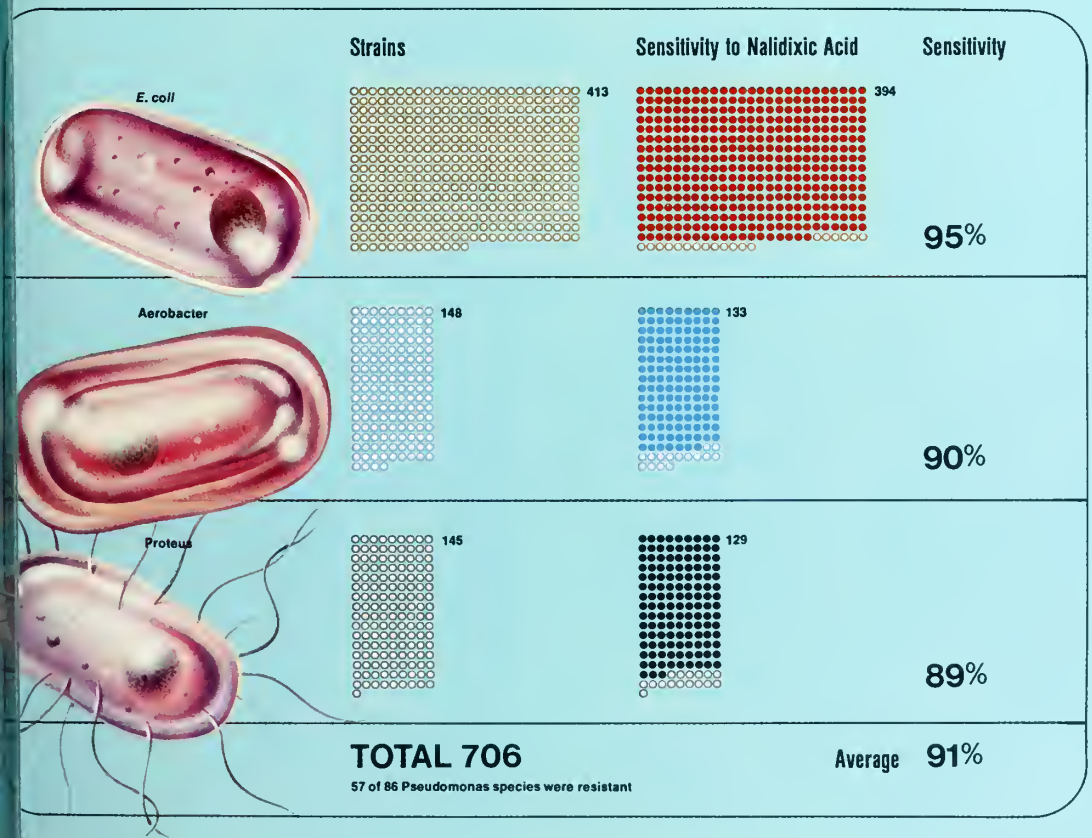
Kinetic Relationship of Acute and Chronic Bacterial Pyelonephritis to Chronic Renal Disease[2]



consistent activity against 706 gram-negative strains

n vitro testing of *E. coli*, Aerobacter
nd Proteus species showed better
han 90% sensitivity to nalidixic acid.[3]
See Table)

letter Than 90% Sensitivity Among 3 Common Urinary Invaders



References: 1. Reimann-Hunziker, R. and Reimann-Hunziker, G. J.: *Praxis 53*:15, Jan. 9, 1964. 2. Sanford, J. P.: *Med. Times 96*:715, July 1968. 3. Reese, L.: *Canad. M. A. J. 92*:394-397, Feb. 20, 1965.

Cybis®
(nalidixic acid)

r the strong start and a fast finish... in cystitis, pyelonephritis, prostatitis, urethritis

Before prescribing, please consult complete product information, a summary of which follows on the next page, including indications, warning, precautions, adverse reactions and dosage.

Summary of prescribing information

Indications: Urinary tract infections in which species of sensitive gram-negative bacteria are predominant, particularly *Proteus, Escherichia coli, Aerobacter, Klebsiella,* and certain strains of *Pseudomonas.* Gram-positive bacteria are less sensitive to Cybis but favorable clinical results have been observed.

Warning: Use in Pregnancy. This drug is not recommended in the first trimester of pregnancy. However, it has been used in several patients during the last two trimesters without producing apparent ill effects in either mother or fetus.

Precautions: Although prolonged treatment with Cybis has been generally well tolerated, as with all new drugs it is advisable to carry out blood, renal, and liver function tests periodically if treatment is continued for more than one or two weeks. The dosage recommended for adults and children should not be arbitrarily doubled unless under the careful supervision of a physician. **It should be used with caution in patients with liver disease, epilepsy, or severe cerebral arteriosclerosis, and in patients in whom kidney function is severely impaired.** Patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving Cybis and, if a photosensitivity reaction occurs, therapy should be discontinued.

During treatment microorganisms may develop resistance to this drug. Resistant bacteria, not previously present or identified, may emerge. Cultures should be taken and bacterial sensitivity tests made periodically, particularly if the clinical response is unsatisfactory or if a relapse occurs. Should resistance develop, other specific chemotherapy should be instituted; no cross resistance has been observed. If new strains of bacteria that are not sensitive emerge, other effective antibacterial agents may be added. When Benedict's or Fehling's solutions or Clinitest® Reagent Tablets are used to test the urine of patients taking Cybis, a false-positive reaction for glucose may be obtained due to the liberation of glucuronic acid from the metabolites excreted. However, a colorimetric test for glucose based on an enzyme reaction (using, for example, Clinistix® Reagent Strips or Tes-Tape®) does not give a false-positive reaction to Cybis glucuronide.

Adverse reactions: Mainly mild nausea, vomiting, and other gastrointestinal disturbances: less frequently, sleepiness, drowsiness, weakness, headache, dizziness and vertigo, and rarely cholestasis, paresthesia, thrombocytopenia, leukopenia, or hemolytic anemia which in some patients may have been associated with deficiency in activity of glucose-6-phosphate dehydrogenase. Itching, pruritus, rash, urticaria, mild eosinophilia, reversible photosensitivity reactions primarily involving exposed surfaces, and reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), occurred occasionally. Reversible increased intracranial pressure with bulging anterior fontanel, papilledema, and headache have been observed occasionally in infants and children. Toxic psychosis and brief convulsions (the latter generally in patients with possible predisposin factors, and both usually associated with excessive dosage) have been recorded in rare instances.

Dosage and administration: *Adults*—Four Gm. da by mouth (2 tablets of 500 mg. four times daily) for o to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. da (1 tablet of 500 mg. four times daily). *Children*—According to age and weight: approximately *25 mg. per pound* of body weight per day, administered in divided doses.

Note: The dosage recommended above for adults a children should not arbitrarily be doubled unless un the careful supervision of a physician. Until further experience is gained, infants under 1 month should be treated with the drug.

How supplied: Tablets of 500 mg., bottles of 50.

Before prescribing, please refer to complete prescribing information.

Cybis®

(nalidixic acid)

for the strong start and a fast finish...
in cystitis
pyelonephritis
prostatitis
urethritis



BREON

BREON LABORATORIES INC.
90 Park Avenue, New York. N.Y. 10016
Subsidiary of Sterling Drug Inc.



Years Revise Attitude Toward Strikes Against The Public Health And Welfare

Fifty years ago next month the Governor of Massachusetts sent to the President of the American Federation of Labor a one-sentence telegram that would make this Governor the 30th President of the United States:

"There is no right to strike against the public safety by anybody, anywhere, any time."

Of Boston's 1,544 policemen, 1,117 had walked out on strike and Calvin Coolidge acted promptly in the public interest. Relatively unknown to that time, he was promptly nominated for the vice presidency and running-mate of Warren G. Harding.

Forty-three years later another Governor acted completely differently when a hospital strike was called by Russian-born Leon J. Davis, president of New York's Local 1199, Drug and Hospital Workers Union. Quietly, despite the fact that Davis had been jailed for contempt, Gov. Rockefeller capitulated and New York's law was changed to allow collective bargaining. New York made it legal "to strike against the public safety by anybody, anywhere, any time."

Not so in South Carolina.

Last January the National Organizing Committee for Hospital and Nursing Home Workers was launched with a donation of $350,000 from that same New York City Local 1199. Charleston, "a gracious city of the old Confederacy," was chosen as the target city.

The Rev. Ralph Abernathy, president of the Southern Christian Leadership Conference, but best remembered in Alabama's capital city for what the newspapers described as a frantic flight from a hatchet-swinging husband in his congregation, joined hands with Coretta Scott King, the widow of Martin Luther King, who once described Local 1199 as his "favorite" union, to lead support to the strike against two Charleston hospitals.

George Meany's AFL-CIO sent $25,000 to support the drive, and Walter Reuther, whose United Auto Workers recently united with Jimmy Hoffa's Teamsters Union to form the American Labor Alliance, contributed a check for $10,000 to the War Chest as a Mother's Day gift! Fast falling in line with purses and promises of support were Roy Wilkins (NAACP), Whitney Young (National Urban League), Roy Innis (Congress of Racial Equality), two big-city Mayors (Carl Stokes of Cleveland, Richard Hatcher of Gary, Ind.), and a score of others, together with the organizations they represent.

At the time of the strike the Hospital of the Medical College of South Carolina had every one of its 460 beds occupied, while, with a week of grace, Charleston County Hospital was able to reduce its peak patient load by half. In the three-month span of the strike the two hospitals used volunteer help (including doctors' wives, "pink ladies," and others) to continue service to the ill and injured.

The Journal of the American Hospital Association mentions Philadelphia and Baltimore as cities that could expect hospital strikes patterned after this one. But if the

three-month Charleston walkout was geographically motivated, as seems very certain, then we may look for other target cities in the Deep South, notably in Alabama.

Remembering the 15-word Coolidge telegram of Sept. 9, 1919: "There is no right to strike against the public safety by anybody, anywhere, any time," and recalling Rockefeller's spineless capitulation in New York, it is well to put alongside those facts the four words voiced by William H. Vanderbilt in a moment of unguarded irritation 85 years ago:

"The public be damned."

Voluntary Sterilization Offers Simple Out For Population Explosion

Forty years ago, when talk of the world's population explosion had not yet begun, an Alabama minister went to his physician seeking counsel. For his wife he wanted an ovariectomy.

"But that," the doctor told him, "can be a very dangerous thing. Fortunately it isn't necessary. There is an alternative that is safe, quick, effective and legal. I can sterilize you here in the office without harm to any of your functions. Let me illustrate."

With charts and photographs ready at hand, the doctor explained to his would-be patient what he would do. At the same time he detailed the hazards surrounding an ovariectomy.

"I'll have to think about that," the minister said, and departed with unseemly haste. He never returned.

Both the doctor and his patient of four decades ago are dead. But it is interesting to read in the *Journal of the American Medical Association* a present day sequel to that long-ago conversation.

Today the population explosion is the most frightening menace looming on the not-too-distant horizon. Just when the conquest of disease seems about to become an accomplished fact, when longevity is assured for most of us, we face the prospect of a billion more people in the world in the next 15 years . . . *with most of them starving.*

Voluntary male sterilization is the obvious answer, says JAMA. There are four varieties of sterilization: eugenic, punitive, therapeutic, and contraceptive. The first two do not fall within the definition of voluntary sterilization. There are no legal bars to therapeutic sterilization in any state, except that Connecticut and Utah have statutes requiring "reasons of medical necessity."

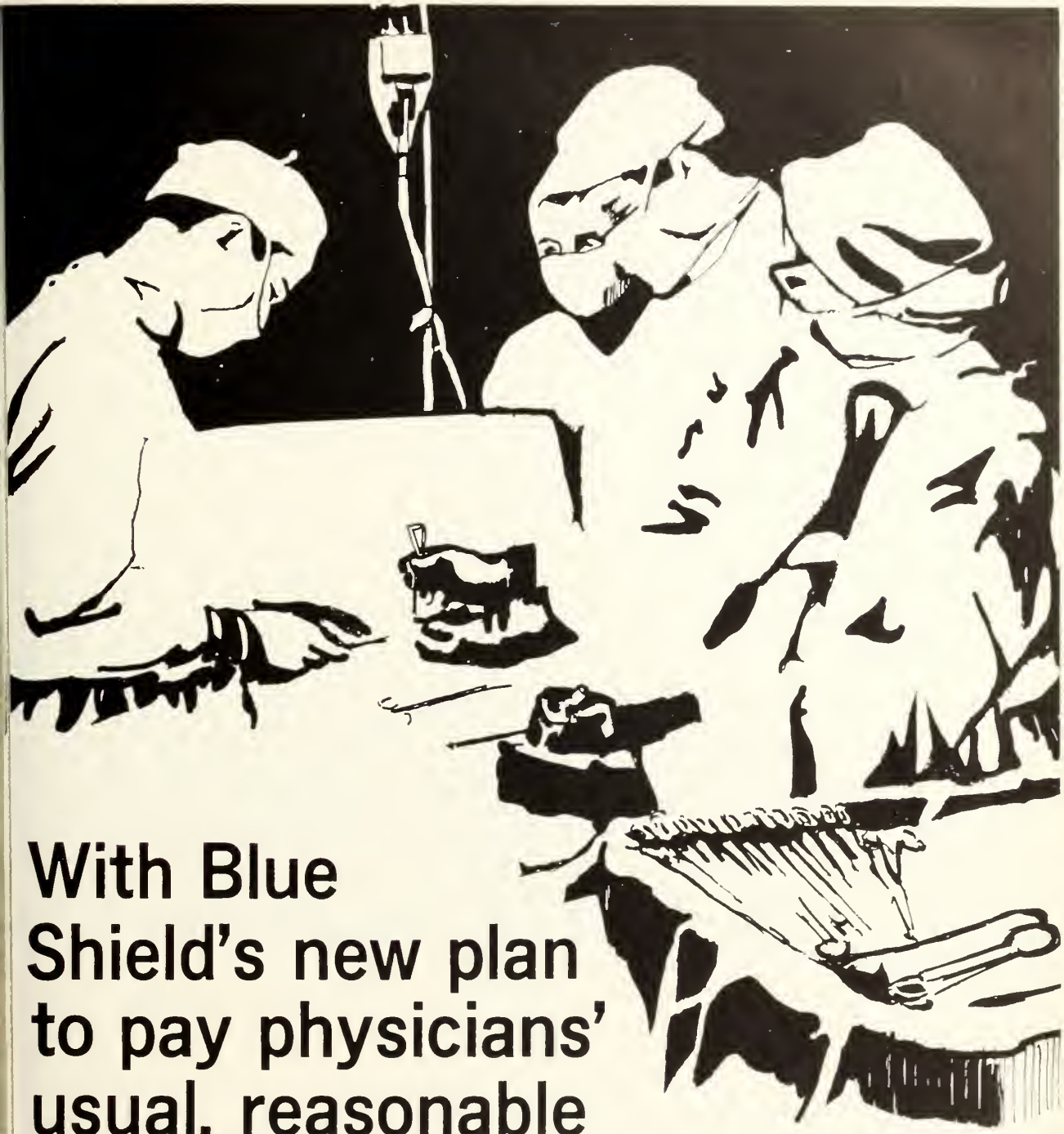
Excepting these two states, contraceptive sterilization is nowhere circumscribed in this country. And Georgia actually has passed a law which assures immunity from criminal or civil suits (excluding, of course, negligent performance) for physicians who perform voluntary sterilization.

Meantime there is an incorporated Association for Voluntary Sterilization, which announced the other day that more than two million living Americans have chosen this method of birth control, which number is increasing presently at the rate of 100,000 a year.

This association is even offering a speaker for interested groups in the person of H. Curtis Wood, Jr., M. D., AVS Medical Consultant, whose usual subject is "Voluntary Sterilization—the Myths and the Facts."

Office vasectomy is now paid for by Blue Shield in at least 34 of the nation's 50 states, and under federal-state Medicaid plans, 35 of these states pay for voluntary sterilization.

We've come a long way in 40 years, haven't we?



With Blue Shield's new plan to pay physicians' usual, reasonable and customary fees, your patients are far less likely to favor methods of government-controlled health care.

BLUE CROSS-BLUE SHIELD OF ALABAMA



It's All Of A Pattern With Campus Unrest And Postponed Maturity

"When a doctor accepts without challenge the statement that medical care is a right, he's been had," writes Marvin H. Edwards, editor of *Private Practice*. "He has no further basis for arguing any man's demand on his time and skill."

Doctors are showing, the editorial continued, "remarkable forebearance in light of the attempts to take away their freedom of practice.

"Edmund Burke once said: 'There is . . . a limit at which forebearance ceases to be a virtue.'

"Doctors, your forebearance has ceased to be a virtue.

"To go along with the planners who would tell you what patients to see, what to prescribe, how to practice, what to charge, is not tolerance; to invite the planners to be your speakers and let them go unchallenged is not tolerance; to agree to their demands is not tolerance.

"It's suicide."

And even as government seeks to infiltrate the ranks of medicine, more and more, Robert Ervin Brown has been sentenced by a California court to one to ten years in prison. With only a Birmingham high school diploma for his educational background, Brown posed as a heart specialist.

Except for his defense attorney, no word of protest was heard from his conviction and sentence.

Nor when chiropractors sought vastly to broaden their area of practice, veenturing far from backbone adjustments, was there initial questioning of them on such subjects as gynecology, roentgenology, geriatrics, physiotherapy, p a t h o l o g y, bacteriology, anatomy, physiology, chemistry, and jurisprudence.

Somehow it seems of a pattern with the indictment of everyone else but the culprits in campus unrest and crime in the streets.

There's A Difference

The difference between the Healing Arts and the Cults is:—

The difference between today and yesterday.

The difference between Astronomy and Astrology.

The difference between the Laboratory and the Crystal Ball.

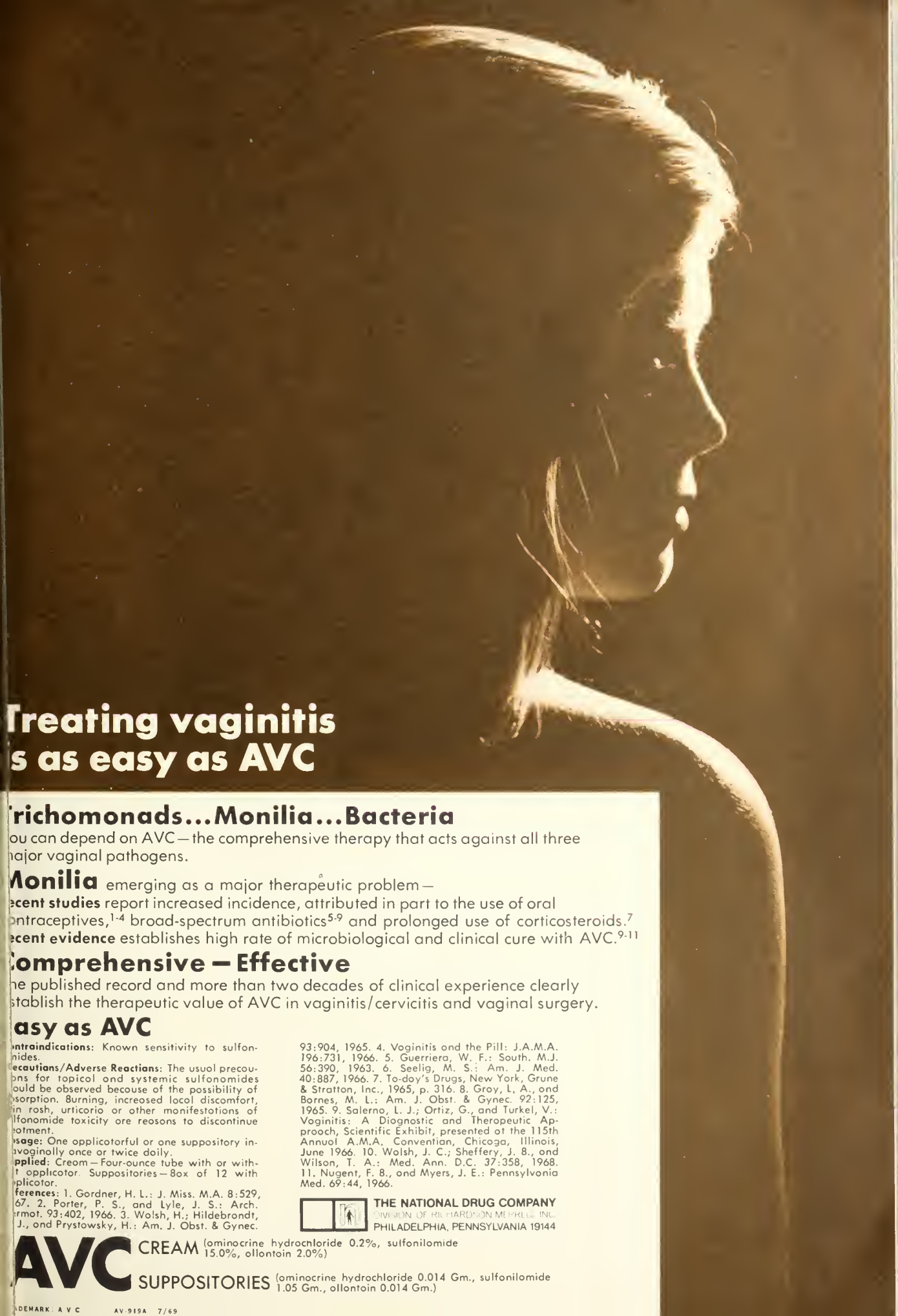
The difference between Psychiatric Treatment and Bedlam.

The difference between Research and Prophecy.

The difference between Knowledge and Superstition.

The difference between an earned degree and an "honorary" degree.

The difference between Medicine and Chiropractic.



Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—

Recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]

Recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive — Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfonamides.

Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonomides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.

Usage: One applicatorful or one suppository intravaginally once or twice daily.

Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

References: 1. Gordner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermot. 93:402, 1966. 3. Walsh, H.; Hildebrandt, J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriera, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. Today's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Bornes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

AVC CREAM (ominocrine hydrochloride 0.2%, sulfonilomide 15.0%, allontoin 2.0%)

SUPPOSITORIES (ominocrine hydrochloride 0.014 Gm., sulfonilomide 1.05 Gm., allontoin 0.014 Gm.)

TRADEMARK: A V C

AV-919A 7/69

in trauma

new Orenzyme® Bitabs

One tablet q.i.d.

Trypsin: 100,000 N.F. Units, Chymotrypsin: 8,000 N.F. Units.; equivalent in tryptic activity to 40 mg. of N.F. trypsin

DOUBLE STRENGTH



Proteolytic enzyme therapy specifically indicated for the rapid resolution of inflammation and edema as adjunctive therapy in accidental and surgical trauma.

1 tablet q.i.d. provides recommended therapeutic dose at lower cost.

4 FULL DAY'S DOSAGE

Description: ORENZYME BITABS offers the therapeutic effects of trypsin in an oral form as adjunctive therapy for the rapid resolution of inflammation and edema. ORENZYME BITABS is convenient to use, promotes patient cooperation and is ideally suited for maintenance therapy following parenteral trypsin.

Indications: When used as adjunctive therapy for the rapid resolution of inflammation and edema, good results have been obtained in:

- ☐ Accidental Trauma
- ☐ Postoperative Tissue Reactions.

Other conventional measures of treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.

Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.

Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.

Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reported but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.

Dosage: One tablet q.i.d.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

TRADEMARK: BITABS U.S. PATENT NO. 3,004,893 4/69 0-821A

Span Of Adolescent Years Doubled—And Youth Crisis Became Inevitable

Adolescents are, as the saying goes, "neither fish nor fowl nor good red herring."

"What has happened to adolescence?" asks Kenneth A. Wells in a recent article in *Texas Medicine*. Generally defined as the period between puberty and maturity, adolescence today takes twice as long for a boy to get through as it did in the first couple of decades of this century, Wells explains. Two generations ago, this period was considered for most boys to be between 13 or 14 and 18 or 19—five or six years. Today the time is from age 12 or 13 to 22 or 23—a span of 10 to 12 years.

Puberty is strictly a biological term, the author says. Maturity is a social term "reflecting rather vaguely the indefinite point at which society accepts the growing individual as an adult or 'mature' member, and allows and expects him to fit the adult society's behavioral norms."

Wells uses these accepted facts in a novel explanation of campus unrest:

"Some of the adolescent's serious problems arise because this period of his life has been greatly lengthened and much of what occupies the time is not sharply or clearly related to his basic developmental tasks. Our adult concern for youth has its paradoxical side: We have extended childhood, relieved youth of adult responsibilities, and then frantically tried to create ersatz tasks that look like responsibilities. We refer to adolescents as 'young citizens,' but there is an artificiality about it all that both we and they know to exist. . .

"On the one hand we say, 'Why don't you grow up an act your age?' In the next breath we are just as likely to say, 'You can't do that—you're not old enough.'"

Might this not very well be an even further extension of the political gimmick of "rights" without corresponding "responsibilities"?

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: MRS. ELIZABETH HARKINS, ACSW, *Coordinator of Admissions* or

CHARLES W. NEVILLE, JR., M. D., *Assistant Professor of Psychiatry and Medical Director*

Area Code 704 - 254-3201

MASA President And Hero In War On Yellow Fever--- His Story

Up to 90 years ago no one suspected the culprit in yellow fever epidemics. A score of years after that, the mosquito was still avoiding positive general recognition. But the season of the year when this dread, often fatal disease struck was no secret.



So in the United States it became the custom for families in the Deep South to flee north from it.

Duty, responsibility and/or pride kept many Southern men from fleeing, and to a special degree doctors and ministers, priests and rabbis.

In every Southern city invaded by this "yellow peril" those who didn't leave, banded themselves in a Can't-Get-Away Club!

Probably many a person reading the newspapers some months ago, of the death of an 88-year-old Ramer doctor, were puzzled, in reading the listing of his honors, to see that he was a member of the "George A. Ketchum Medical Society."

What is that society? And who is the doctor for whom it is named? The answers to both questions are found in Mobile, where the fountain in Bienville Square is named for Dr. Ketchum, and where there is actually another doctor who is a member of this same society. Dr. J. Mac Bell, retired pediatrician, explains that the society existed only so long as the Medical College of the University of Alabama was located in Mobile.

Dr. George Augustus Ketchum was a newspaper headliner in his day, beginning back before the war that sliced a nation apart with wounds that are visible to this very moment, like it or not. He represented Mobile in Montgomery as war clouds lowered and was among those who signed the articles of secession.

He would probably have guffawed appreciatively in later years over Ambrose Bierce's definition of Yankee in his *Devil's Dictionary*:

"Yankee: To a European, an American; to a Northerner, a New Englander; to a Southerner there is no such word. (see damyankee)."

And of course there is no such entry as "damyankee" in the *Devil's Dictionary*!

While Dr. Ketchum had all the spirit of a warrior and all the courage of a patriot, he was much more interested in saving lives than in taking them. His long, rich and rewarding life was testimony to the fact.

On Dec. 30, 1897, in the Manassas Club of Mobile, 60 members of that city's Can't-Get-Away Club gathered to honor a fellow member and a doctor, this same Dr. Ketchum. He was presented with a silver service "as a small testimonial of our exalted appreciation of his character and worth."

Born in Augusta, Ga., April 6, 1825, when John Quincy Adams had been president of the United States just five weeks, with only five presidents before him, George Ketchum became an Alabamian ten years later when his family moved to Mobile.

His father's business reverses stopped him from entering Princeton as a sophomore at the age of 16. He taught for a year at the female academy at Livingston before beginning the study of medicine. His formal studies continued at South Carolina Medical College before going on to graduate from the University of Pennsylvania in medicine in 1846. In the two years following he had his initiation into practice in battling two yellow fever epidemics, using heavy doses of quinine as his weapons.

Elected physician to the city hospital in 1848, in the same year, with other Mobile doctors, he established a private infirmary for Negroes, which continued in popular use until the close of the War Between the States. In 1858 he was one of a group organizing the Medical College of Alabama and was dean of the faculty of that school at the time of his death, 48 years later.

In 1861, Dr. Ketchum was one of four Mobile delegates to the secession convention in Montgomery, and signed the secession resolution. He was commissioned surgeon of the 5th Alabama Regiment, but, as Mobile had been emptied of medical services by the lure of combat, he found his greater call to serve at home.

In 1847 Dr. Ketchum took part in the organization of the Medical Association of the State of Alabama and was its first secretary. He also took part in its reorganization after the war and was its president in 1874. He was a member of the Mobile Medical Society from the date of its organization and was several times its president. In 1871 he was elected president of the Mobile board of health, a position he held until after the turn of the century.

Many honors and expressions of appreciation and recognition were showered on Dr. Ketchum through the latter years of his life, including the silver service from the Can't-Get-Away Club, the bronze fountain in Bienville Square, the medical society named for him; on Nov. 23, 1898, he and Mrs. Ketchum, the former Susan Bertram of Mobile, celebrated their Golden Wedding Anniversary; Mrs. Ketchum died on the date of their 54th anniversary and Dr. Ketchum survived her by two years.

The Ketchum medical society may have vanished from memory, along with the dread disease he fought so hard against. But the name of George Augustus Ketchum, M. D.,is preserved on a fountain in Mobile and in the roster of past presidents of the Medical Society of the State of Alabama.

Course In Mental Health

The National Institute for Mental Health has awarded two grants totaling more than a half million dollars to the University of Pittsburgh School of Nursing to develop a new master's degree program in psychiatric-mental health nursing and to integrate mental health content into the undergraduate degree program.

Hundreds of doctors every year flee to other countries from the dismal professional life in enlightened, jolly old England where doctors are servants of the state. (Dr. Edward R. Annis, past president, AMA).

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9



Clues to PVD

The heavy smoker with vasospasm

He may be comparatively young or approaching middle age. Typically, he is a heavy cigarette smoker—a pack or more a day for a number of years. Whether smoking is a causative or an important exacerbating factor in peripheral vascular disease is still under discussion. But the vasoconstrictive effects of nicotine are firmly supported by a substantial body of laboratory and clinical evidence, and the close association is now generally accepted.

Thus, a history of heavy smoking coupled with vasospasm may serve as warning signals to the physician. When a diagnosis is established, therapeutic measures are directed toward increasing the local circulation, and appropriate management of the patient's general medical needs should be instituted. These include the important safeguards of keeping warm and refraining from smoking.

Before prescribing Roniacol Timespan (nicotinyl alcohol tartrate), please consult complete product information, a summary of which follows.

Indications: Conditions associated with deficient circulation; *e.g.*, peripheral vascular disease, vascular spasm, varicose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets morning and night.

How Supplied: Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

mportant in
otal management of
peripheral vascular disease,
vascular spasm or
hilblains

Roniacol® Timespan®
(nicotinyl alcohol tartrate)

or relief of ischemic symptoms

venience of b.i.d. dosage—sustained-release Timespan Tablets usually provide
onged relief of ischemic symptoms with two doses daily.

othness of onset—the action of Roniacol (nicotinyl alcohol) is smooth and
dual in onset, rarely causing severe flushing.

ctivity of action—relaxes the musculature of peripheral blood vessels.

h degree of safety—side effects seldom require discontinuation of therapy.

Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic/antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other C depressants. As with all CNS-acting drugs, c tion patients against hazardous occupations quiring complete mental alertness (*e.g.*, operat machinery, driving). Though physical and p chological dependence have rarely been repor on recommended doses, use caution in ministering Librium (chlordiazepoxide hyd chloride) to known addiction-prone individ or those who might increase dosage; withdra symptoms (including convulsions), follow discontinuation of the drug and similar to th seen with barbiturates, have been reported. of any drug in pregnancy, lactation, or in wor of childbearing age requires that its poten benefits be weighed against its possible haza As with all anticholinergic drugs, an inhibi effect on lactation may occur.

PRECAUTIONS: In elderly and debilita limit dosage to smallest effective amount to clude development of ataxia, oversedation confusion (not more than two capsules per initially; increase gradually as needed and to

or here.



). Though generally not recommended, if bination therapy with other psychotropics es indicated, carefully consider individual macologic effects, particularly in use of po- ating drugs such as MAO inhibitors and othiazines. Observe usual precautions in ence of impaired renal or hepatic function. doxical reactions (*e.g.*, excitement, stimula- and acute rage) have been reported in psy- tric patients. Employ usual precautions in ment of anxiety states with evidence of im- ling depression; suicidal tendencies may be ent and protective measures necessary. Vari- effects on blood coagulation have been rted very rarely in patients receiving the and oral anticoagulants; causal relation- has not been established clinically.

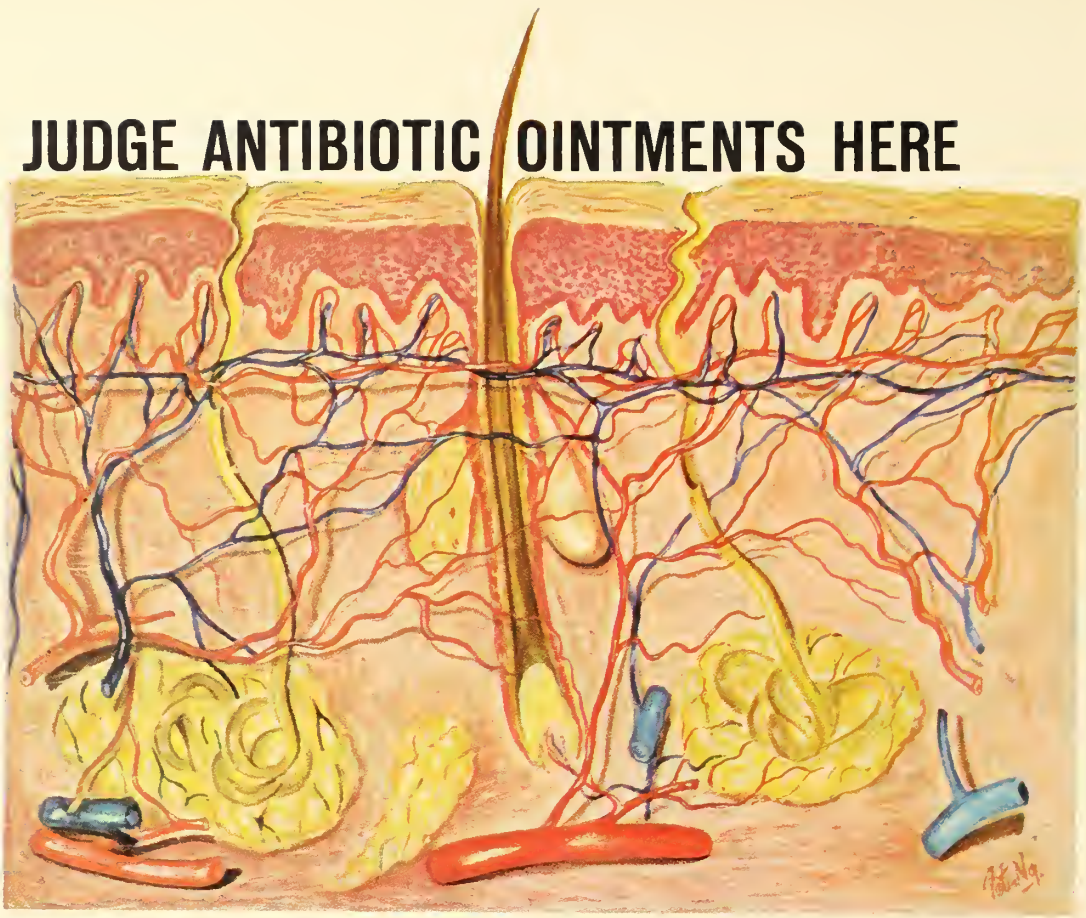
VERSE REACTIONS: No side effects or festations not seen with either compound e have been reported with Librax. When rdiazepoxide hydrochloride is used alone, siness, ataxia and confusion may occur, cially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Decorated Combat Flier Becomes MASA and ALAPAC Leader

With 40 combat missions in the South Pacific to his credit, an Alabama boy returned from World War II to earn both his B. S. and M. D. degrees from the University of Alabama, to enter general practice in his native Marshall County, and to become a leader in professional, civic and political affairs of his community and his state.



Dr. Porch

Professionally he is chairman of the Madison County Medical Society's Board of Censors, chairman of the Medical Aspects of Sports committee for MASA, member of the board of directors from the 7th Congressional District for ALAPAC, and a member of AMA, SMS, AAGP, TVGPA, and on the staff of Arab, Guntersville and Cullman Hospitals.

In civic affairs, he is on the boards of directors of Trans Southern Corporation and Security Bank & Trust of Arab, is a member of the Arab Lions Club, the Arab Quarterback Club, the Arab Masonic Lodge, Zamora Temple of Birmingham, the Marshall County Association for Retarded Children, and is active in the Educational and Athletic Scholarship Program of the University of Alabama.

His military decorations include the Distinguished Flying Cross and the Air Medal with Five Clusters. And as ALAPAC director for the 7th District, he is able to point to his own Marshall County as the only county in Alabama that can boast 100 per cent ALAPAC membership from the Medical Society.

Dr. and Mrs. Porch have a son, Ellis, Jr., and two daughters, Sandra and Christy.

Laboratories Have No Time To Stop, Look And Listen

John J. Horan, executive vice president and general manager of Merck Sharp & Dohme, in a Las Vegas speech answered critics of the wholesale pharmaceutical industry in this way:

". . . we have reached the stage described by President Lincoln when he said: 'If I were to try to read, much less answer, all the attacks made on me, this shop might as well be closed for any other business'.

"That we have not closed shop is clear when we recall that during the decade of continuous criticism there has come from industry laboratories a long list of new drugs, many of which represent revolutionary advances in therapy. Diuretics, beginning with the thiazides; major new antihypertensive agents; oral contraceptives; new products to induce pregnancy or prevent abortion; a host of new antibiotics to widen the physicians' choice and overcome resistant organisms; new oral antidiabetic agents; a new drug effective against tuberculosis; the first truly effective antifungal agent; a systemically effective trichomonacide; new antiinflammatory drugs and new one for gout; the first chemotherapeutic agent prophylactic against a viral disease; significant new tranquilizers for emotional disorders and the first effective antidepressants which replaced some of the need for electroshock therapy; new nonaddicting analgesics; drugs for the treatment of rare diseases such as Wilson's disease and problems associated with biliary cirrhosis; five anticancer agents; vaccines for measles and mumps."

Norflex®
(orphenadrine citrate, 100 mg.)



Take the agony out of low back pain... Norflex® (orphenadrine citrate) relaxes the muscles in spasm.

Restore mobility and hasten recovery... prescribe Norflex 1 tablet b.i.d.

Indications: Acute spasm of voluntary muscles, regardless of location; especially post-traumatic, discogenic, and tension spasms. **Contraindications:** Due to its anticholinergic action, NORFLEX should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcer, prostatic hypertrophy or obstruction at the bladder neck, cardiospasm (megaesophagus) and myasthenia gravis. Use with caution in patients with tachycardia. Do not use propoxyphene (Darvon®) concurrently. **Adverse Reactions:** Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Adverse reactions are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported. **Dosage and Administration:** Two tablets per day for adults, regardless of weight or sex; one in the morning and one in the evening. Each tablet contains 100 mg. orphenadrine citrate.
For full information, see Package Insert or P.D.R.

Norflex®
(orphenadrine citrate)

Riker Laboratories
Div. of Dart Industries Inc.
Northridge, California 91324

The Riker representatives in your area are:
Robert Johnston
Billy J. Phillips
William O. Crabb
Paul E. Loeffler III

Diabetes Education Program

A recent diabetes patient education program was conducted by the Municipal Hospital in Worthington, Minnesota, a city of just over 9,000 population. The first set in a series of meetings, lasting three to four hours each night, took place on five successive evenings.

The objective was to help the diabetic patient and his or her spouse or parents learn more about diabetes and how it may be controlled. The program was conducted by an internist, a pediatrician, an ophthalmologist, a dietitian and a nurse. The fee for the course was $10 per family, and each participant was required to have the approval of his physician.

Each session was attended by 20 to 25 persons, some coming from communities at distances of 40 to 60 miles. On every occasion two informal talks were given on subjects of practical importance to an understanding of diabetic management: "What is Diabetes?" "Insulin and Its Use and the Effect of Exercise," "Oral Hypoglycemic Agents and Their Use," "Acute Complications—Insulin Reactions and Diabetic Acidosis," "Long-Term Complications," "Diet Planning," "Personal Hygiene," etc. A pertinent film strip concluded each session. Time was allowed for individual conferences with physician, nurse or dietitian.

Rehabilitating Arthritics

Improved rehabilitation services will soon be available to thousands of men and women now crippled with arthritis. Through a cooperative agreement between the Arthritis Foundation and the Department of HEW, a program is being set up to hasten the rehabilitation of arthritis patients and to increase opportunities for their return to employment. About 13 million Americans reportedly suffer from the disease, and over three million report that it limits their activity.



Darvon®
Compound-65

Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

Lilly

Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206.

900252

THE JOURNAL
of
THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA
Published Under the Auspices of the Board of Censors

Volume 39 August, 1969 No. 2

Renal Angiomyolipomas: Report of Two Cases and Review

Henry C. Hudson, M. D., George F. Scofield, M. D.,
Rube Hundley, M. D., William Gates, Jr., M. D.
Birmingham, Alabama

Hamartomas are defined as tumors made up of mature normal cells arising from the organ in which they are found. The disorganization, the overgrowth and the encapsulation clearly indicate the anomalous status of such masses. They may occur in any organ in the body but are most common in the spleen, liver, kidneys, lungs and pancreas. These tumors are mesenchymal in origin.

The angiomyolipoma is one of the most controversial types of renal hamartomas. These lesions are benign tumors characterized by the presence of fat, smooth muscle and blood vessels. There has been considerable confusion as to the nomenclature, histogenesis, and malignant potential of these tumors. In the latter of these controversial points the consensus seems that despite certain malignant potentialities they are benign tumors. In a review of the literature no one has ever clearly demonstrated metastasis.

The purpose of this paper is to report two cases and briefly review the literature on symptomatic angiomyolipomas unassociated with tuberous sclerosis.

Case Report Number 1

A 71 year old diabetic white female was admitted 7-26-66 to Carraway Methodist Hospital with the complaint of pulling sensation in the left flank and back pain for two or three months' duration. There had been no sudden colic like pain. The patient's diabetes had been controlled for 20 years and she was taking 30 units NPH insulin daily. Gross hematuria or other G. U. complaints were not reported. The patient had not had fever. The past medical history was noncontributory, except for a history of an appendectomy and thyroidectomy some 10 years prior to this admission. The patient had been on digitalis for several years because of congestive heart failure. Physical examination revealed a normotensive, elderly white female in distress. The positive findings were limited to the abdominal cavity. A nontender, movable, mass was palpated in the left abdomen, extending to the left superior iliac crest. The lateral and medial borders were not discrete. Laboratory studies revealed a normal blood count and urinalysis. The blood urea nitrogen was 23 mg. per cent, the creatinine was 2.0 mg. per cent. An



Figure 1



Figure 2

intravenous pyelogram showed a mass in the left side of the abdomen, its lower border at the level of the iliac crest with the upper border at the inferior pole of the kidney. The mass measured some 12 cm. in diameter and had a radiolucent center. The collecting system of the kidney was not displaced or distorted. The impression was a cyst or lipoma (figure 1). On 8-5-66 the patient underwent an exploratory laparotomy by a general surgeon. A large mass involving the lower pole of the left kidney was found. A left nephrectomy was done by one of the authors without any difficulty. The post-operative course was uneventful and she was allowed home on 8-18-66 in good condition.

Pathological findings: Gross

The surgical specimen consisted of a left kidney with a fatty tumor mass attached to its lower pole. The entire mass and kidney weighed 500 grams. On bisected surface an ovoid, lobulated, yellowish tumor which measured 12 cm. in diameter was attached to the lower pole of the kidney. It was largely extrarenal being attached to the capsule in one small area (figure 2). The tumor was solid showing no areas of cystic, hemorrhagic or necrotic changes. The tumor was well encapsulated. The kidney and pelvis were not distorted, and did not definitely involve the parenchyma of the kidney. In one area immediately adjacent to the kidney the tumor was much firmer than in other areas and there was questionable extension of the lesion through the capsule of the tumor.

Sections of the tumor revealed a pseudo-capsule of compressed connective tissue. The tumor itself was made up of fat with varying amounts of loose to dense fibrous connective tissue. Interspersed throughout the tumor were many large thick-walled blood vessels which actually formed almost plexiform anastomoses (figure 3).

The sections of the adjacent kidney

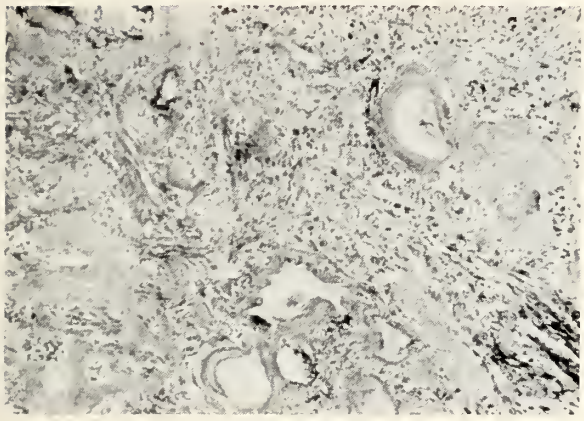


Figure 3

parenchyma showed the characteristic lesion of diabetic intercapillary glomerulosclerosis (Kimmelstiel-Wilson disease).

Case Report Number 2

A 55 year old white male was admitted to Carraway Methodist Hospital for the evaluation of left upper quadrant pain of several months duration (May, 1968). A routine workup revealed no evidence suggesting the cause of the pain. An intravenous pyelogram was done, and an abnormality of the lateral border of the kidney was noted, suggestive of fetal lobulation or tumor (figure 4). Nephrotomography did not further delineate the suspected lesion on the left. Selective renal arteriography was then done bilaterally and the left kidney was found to be normal. Surprisingly, a tumor was noted in the right kidney (figure 5) on arteriography, and in retrospect, a very lightly stippled calcified area measuring some 3 cm. in diameter and located in the lateral border of the right kidney could be seen on the previous IVP. A clinical diagnosis of hypernephroma was made, and exploration of the right kidney was done. At the time of surgery, a lesion measuring 5 cm. was noted, and a frozen section was done which suggested malignancy. A right nephrectomy was then performed.

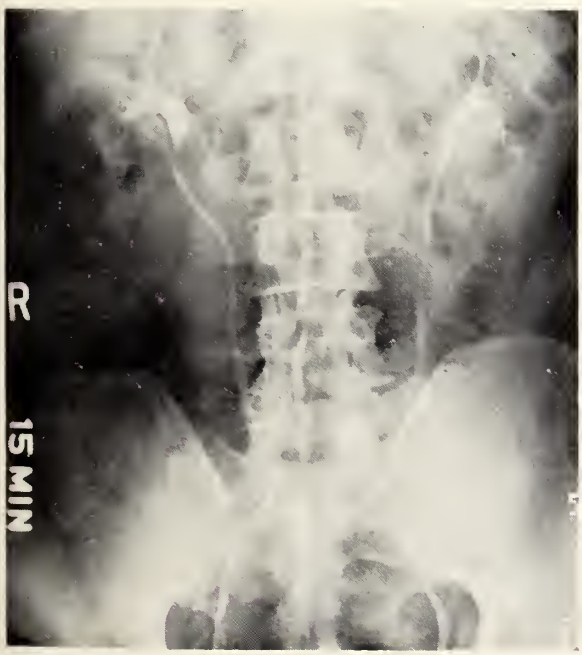


Figure 4—Intravenous pyelogram, Case No. 2



Figure 5—Selective renal arteriogram, Case No. 2

Pathological findings:

The kidney weighed 265 grams and measured 15 x 8 x 4 cm. Projecting above the capsular surface of the kidney was a firm tumor nodule measuring 5 cm. in diameter (figure 6, 7, 8). A smaller nodule measuring 1 cm. across protruded above the surface of the kidney in an adjacent area. The larger tumor appeared to be pedunculated with a 1 cm. pedicle. The tumor had a reddish purple color and a variegated appearance. The cut

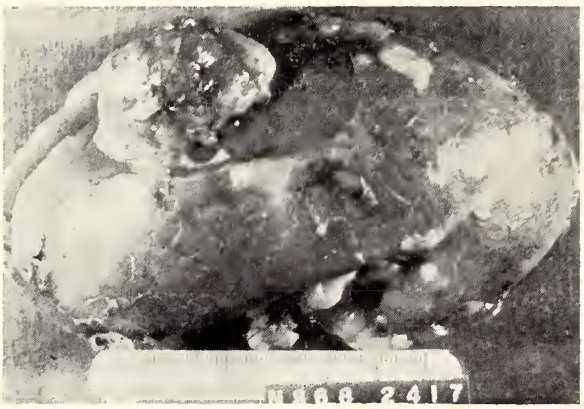


Figure 6

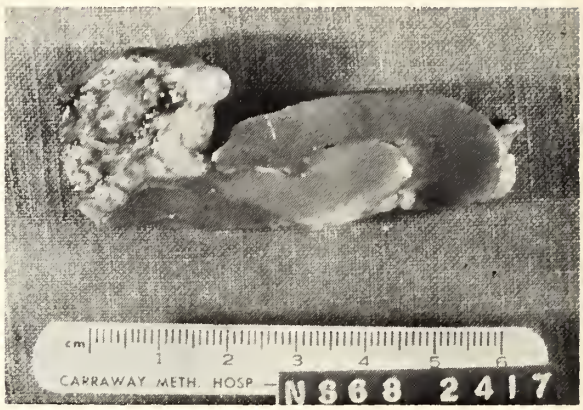


Figure 8

surface was reddish to yellow and bulged above the cut surface. On section through the larger pedunculated tumor, there was an area of hard calcification which had to be decalcified before sectioning.

Microscopic examination (figure 9) revealed the tumor to be a pedunculated lesion which extended into the cortical area of the kidney. Large, thick-walled vessels were seen at the junction. The tumor was made up of rather orderly spindle-shaped cells. Wide areas of hyalinized tissue which took a

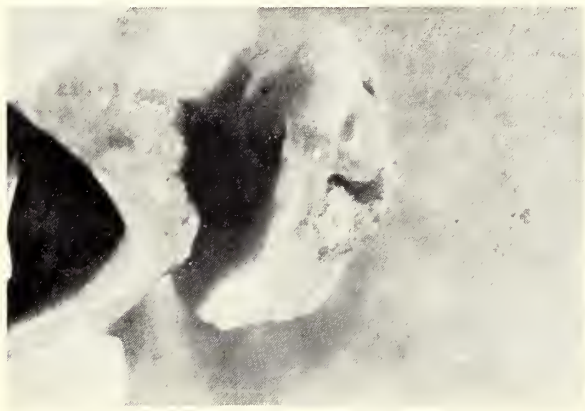


Figure 7

collagen stain on trichrome staining were seen. Spindle-shaped cells took a stain similar to smooth muscle. There was a very prominent vascular component with dilated vessels. Fatty areas were evident in the tumor, as were areas of calcification. Two smaller tumors were noted which were adenomas of dilated tubules and in some areas, clear cells. The clear cells had more the appearance of histiocytes than tubular epithelium. There were some cholesterol clefts in the adenomas. The remainder of the renal parenchyma showed no histopathological alteration. Pathological diagnosis was "right kidney with pedunculated angiomyolipoma and multiple (2) tubular adenomas."

The patient was discharged on the 8th postoperative day doing well. To date, he has

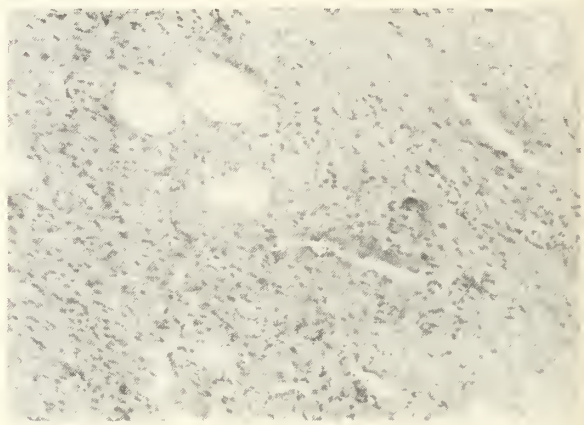


Figure 9—Microscopic section, Case No. 2

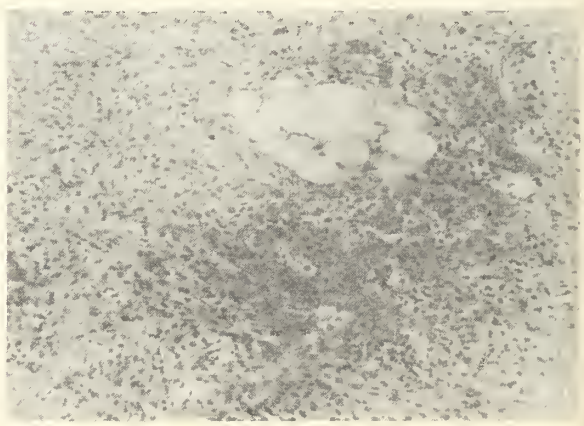


Figure 9—Microscopic section, Case No. 2

had no further difficulty. The cause of the left upper quadrant pain was not demonstrated and was felt to be a musculoskeletal complaint.

Review of Literature

Reports in the literature of symptomatic angiomyolipomas, unassociated with tuberous sclerosis are somewhat limited. In a review of the English literature 72 cases have been reported, some 51 of these since 1958 (see table No. 1). Robertson and Hand[11] in 1941 reported two cases of their own and collected 12 other cases from the English literature, one of which was asymptomatic. Klapproth, Poutasse and Hazard[5] likewise reported four cases of their own and reviewed 17 cases in the English literature from 1948 to 1959. However, they failed to include the two cases of Robertson and Hand.[11] Also one of their cases was an incidental necropsy finding. Perow and Gray reported two cases unassociated with tuberous sclerosis but only one was symptomatic. Their second case was discovered incidentally in the left kidney on a patient who was admitted for right renal calculus and colic. Khilnani and Wolf[4] reported six cases of renal angiomyolipomas, one of which was asymptomatic. This was discovered following an automobile accident. This patient was followed two years without change and then explored.

In 1965 Price and Mostofi[10] published a detailed analysis of 30 cases of asymptomatic angiomyolipoma that were unassociated with tuberous sclerosis. Their cases were taken from the Kidney Tumor Registry of the American Registry of Pathology. The clinical and pathological features of all 30 patients are reviewed in detail.

Clinical Features

Hamartomas occur most frequently in the fifth and sixth decades. In the past ten years renal angiomyolipomas have become recognized in two separate varieties. (1.) One in association with tuberous sclerosis and (2.) those where no evidence of the latter is demonstrated. Those tumors in association with tuberous sclerosis tend to be in a younger age group, with equal sex distribution. Often these are bilateral, small tumors and are multifocal. The lesions are nearly always asymptomatic. Most of these tumors are found incidentally at autopsy.

Those that are not associated with tuberous sclerosis tend to occur predominantly in the female (41 were females in the cases reviewed). These lesions tend to be large, unilateral symptomatic tumors, necessitating surgical removal.

In contrast to Khilnani and Wolf's[4] observations that most of these tumors are found incidentally, our review of the literature reveals that the majority of them are symptomatic. They found in their five symptomatic cases that most often, there is a history of flank or abdominal pain. The event initiating this is usually hemorrhage into or around the tumor. In our review, hemorrhage was present in 41 cases, tumor necrosis in two cases and eight cases had neither. Vasko, Brockman and Bomar[15] reported one case and reviewed seven other previously reported cases of massive hemorrhage associated with renal angiomyolipomas. One of these cases was associated with tuberous sclerosis. That hemorrhage should be associated with these tumors is not surprising in view of the abnormal structure of the blood vessels. Fever is sometimes present and may well be a manifestation of necrosis within the tumor. Despite hemorrhage into the tumor the incidence of hematuria is low. In well over half of the cases a palpable abdominal mass was present.

Diagnosis of renal angiomyolipomas preoperatively is almost impossible since roentgenographic or other findings are not characteristic. Intravenous or retrograde pyelograms usually reveal a filling defect in the collecting system or displacement of the entire kidney with evidence of a mass. The problem of roentgenographically distinguishing a fatty tumor of the kidney from other tumors that arise in the same area has been

TABLE NO. 1

SUMMARY OF SYMPTOMATIC RENAL ANGIOMYOLIPOMA REPORTED IN ENGLISH LITERATURE SINCE 1958

Author	Year	Age	Sex	Clinical Symptoms	Pathological Findings	X-Ray Findings
Summarized 12 previously reported cases				(1948-1957) and reported 4 additional cases of his own.	One hemorrhage; One central necrosis; Two without hemorrhage.	
Klapproth, Poutasse Hazard[7]	1959	3 1	F. M.			
MacDougall[7]	1960	34	F.	Abdominal pain and right iliac fossa. P. E. Marked tenderness rt. iliac fossa. No loin tenderness.	Tumor of upper pole with hemorrhage in area. 4 x 3, 1.5 cm.	Retropyelogram: Distortion of the pelvis, calyceal system suggesting an upper pole mass. Aortogram: Mass compatible with tumor of upper pole.
Perow & Gray[9]	1960	38	F.	Pain left loin: tender on palpation. Shock.	Large tumor perched over upper pole of kidney 5 x 3.5 x 3 cm. Denudate outer surface of kidney had six distinct tumors. Hemorrhage present in large tumor.	Flat plate—Bladder occupying left hemiabdomen.
Khilnani & Wolf[4]	1961	41	F.	Acute colic pain lt. lower quadrant. Low back pain 13 yrs. P. E. Mass in lt. flank.	Lower ⅔ of kidney replaced by tumor mass 12 cm. in diameter.	IVP revealed distorted calyces upper pole: retrograde confirmed this.
		24	F.	Painful mass rt. flank. Mass present 6 mos. P. E. Mass rt. lower quadrant & rt. upper quadrant.	Upper pole with subcapsular hemorrhage. 7 cm. tumor in substance of kidney. Satellite masses scattered throughout kidney.	Retrograde revealed collecting system to be displaced toward midline. Confluent lucent areas noted adjacent to kidney. Presence of lucent areas replacing renal parenchyma led to diagnosis of lipomatous tumor kidney.
		51	F.	Rt. flank pain for 5 days duration. P. E. Tender mass right flank.	Upper ⅓ kidney. 5 x 5 cm. tumor with area of hemorrhage.	Flat plate: Obliterated right psoas muscle. IVP: marked medial displacement of collecting system of the right kidney. Compression of superior calyx.
		29	F.	Right flank pain 3 weeks duration. P. E. Large mass right flank.		
					Largest mass in lower pole with smaller ones throughout kidney. Hemorrhagic cystic areas.	IVP: Pelvis & calyces displaced toward midline with inferior stretching of lower calyx.
					2nd surgery on left tumor in left lower pole of kidney, biopsy done.	3 months after original surgery on patient, patient's IVP showed lucent area in left kidney lower pole with dil. of calyces.
		52	F.	Left flank mass. P. E. Ballotable tender left flank mass.	Tumor in lower pole within kidney parenchyma 12 cm. in diameter. Central necrosis & hemorrhage.	IVP: mass lower pole of kidney, lower calyx distorted. Lucent area in lower kidney.
Yekel & Tesluk[10]	1961	56	M.	Left flank pain, following accident. Mass in flank.	Hemorrhage massive. Tumor lower pole. 6 cm. in diameter.	Distorted calyceal system on IVP. Flat plate: Mass left flank.
McQueeney, Dahlen, Gebhart[5]	1964	35	F.	Intermittent left flank and abdominal pain for 12 yrs. duration. P. E. tender lower abdomen; no masses.	Upper pole. 2.0 cm. intracystic tumor. No hemorrhage described.	IVP: dilatation of upper calyces on left.

Vasco, Brockman & Bomar[15]	April 1965	46	F.	Right flank pain, syncope, weakness 12 hours post laboratory. P. E. Shock, fresh surgical dressing. 5 months later more right flank pain. Re-explored original hematoma. No tumor.	Lemon size tumor upper pole ruptured with massive hemorrhage.	IVP: marked infra-lateral displacement of right kidney; oblit. psoas shadow.
				Present a detail study of 30 cases of symptomatic angiomyolipoma collected from files of		
Price & Mostofi[10]	June 1965	22 8	F. M.		25 with associated hemorrhage; 4 without; 1 tumor necrosis.	A. F. I. P. and the American Kidney Tumor Registry of Pathology (one of their cases previously reported 1957 by Buckley & Drinker.)
Allen & Risk[2]	Sept. 1965	54	F.	Pain in right lower quadrant. P. E. Pain in right lower quadrant tender.	Lower pole right kidney. 4 cm. in diameter old hemorrhage seen.	IVP & GI Series—retroperitoneal mass below right kidney displacing kidney medially but not distorting collecting system. Aortogram—normal.
		65	F.	Left flank pain. P. E. No mass but tender.	Upper pole of kidney mass in center cystic Gerota's fossa hemorrhage.	IVP: no visualization on left, retrograde-? mass left kidney although collecting system not distorted.
		61	F.	Vague pain left flank. P. E. Vague mass left flank.	Middle & lower pole ¾ of parenchyma involved recent hemorrhage; mass extended through capsule into perirenal fat.	IVP: distorted calyces—mass in middle and lower kidney.
		52	F.	Left flank pain & fever. P. E. Tender mass left flank.	Friable tumor lateral aspect of kidney infiltrating through and perirenal fat and hemorrhage & necrosis.	IVP: space occupying lesion lateral aspect left kidney, suggestion of soft tissue mass.
		63	F.	Chronic pain left flank. P. E. Tender left flank mass. 6 months later right kidney explored and tumor mass biopsied.	Upper pole tumor mass. Primarily extrarenal with nodules in parenchyma. Recurrent hemorrhage in Gerota's facia.	IVP: large mass arising from medial aspect of upper pole, pushing collecting system inferiorly.
Adelman[1]	Oct. 1965	57	F.	Right side pain 1 week. P. E. Tender mass right flank.	Lower pole tumor 7.5 cm. diameter, recent hemorrhage, similar nodules in parenchyma.	IVP: large mass inferior pole of right kidney. Lower calyx pressure changes. Lucent center with 2 mm. thick capsule. Preop diagnosis of lipoma of hemartoma.
Love & Frank[9]	Oct. 1965	32	F.	Right upper quadrant pain—intermittent. 3 years. P. E. Hard tender right upper quadrant mass.	Lower pole tumor 8 cm. in diameter. Well delineated from parenchyma.	IVP: right collecting system displaced upward, flat, elongated right lower pole calyx. Renal angiogram—compatible with tumor of lower pole.
Present Author	1966	71	F.	Left flank & back pain—6 months. P. E. Mass left lateral quadrant.	No hemorrhage described. Lower pole 12 cm. across.	
	1968	55	M.	No symptoms referable to right kidney. Tumor found incidentally when investigating abdominal pain.	5 cm. in diameter.	Arteriogram showed small mass projecting from lower ⅓ of the lateral border of the right kidney.

reviewed by several authors, (Khilnani and Wolf). They have divided the roentgen features of lipomata of the kidney into two groups, (1.) findings indicative of a mass (displacement of pelvis and calyces as a whole rather than invasion of a portion of the pelvis or parenchyma); and (2.) findings indicative of fatty tissue within the mass (lucent areas). These areas as nondemarcated, mottled shadows consisting of irregular lucent zones. They may or may not be obvious and frequently are so faint that only a careful search will reveal them. Hemorrhage which is common may mask the expected lucent areas. On the aforementioned basis, Adelman[1] reported a case pre-operatively diagnosed as a fatty tumor of the kidney. Angiographic features of angiomyolipomas have been discussed by Love and Frank[6] with a report of one case. It was their impression that angiographic studies of these tumors demonstrated vascular patterns similar to malignant tumors. In the 51 cases reviewed only five had angiographic studies done (see chart). In two cases by Klapproth et al,[5] one showed bilateral lower pole vascular masses, the other a lower pole tumor. When bilateral roentgenographic evidence of tumor masses is present one must include renal angiomyolipomas in the differential diagnosis. In this summary of 51 cases there were four that had bilateral involvement. One of these reported by Klapproth et al[5] was diagnosed pre-operatively as polycystic kidney disease.

Treatment in almost all cases has been nephrectomy. Of the 47 cases reviewed since 1958 that had unilateral tumors 44 had total nephrectomy, two biopsies and one partial nephrectomy. In the two cases of bilateral renal angiomyolipomas reported by Khilnani et al[4] both had right nephrectomies done. One had subsequent open biopsy of the left renal tumor and died ten days later from massive hemorrhage. In the other case at the original surgery a soft lipomatous mass could be felt in the left kidney but no further surgery was described with the patient doing well one year later. The bilateral case reported by Allen and Risk[2] had a left nephrectomy originally. This was followed in six months with exploration of the right kidney and removal of the tumor portion of the kidney. The fourth bilateral case reported by Klapproth et al[5] had separate explorations of both kidney masses with biopsy of the tumors. Almost one year later, because of recurrent pain and progressive enlargement of both kidneys, bilateral partial resection of the tumors was done through one incision. These authors have emphasized the difficult clinical problem when renal angiomyolipomas are encountered bilaterally. It is characteristic of these tumors to be highly vascular so that hemorrhage is common.

The gross and microscopic characteristics of these tumors has been described numerous times by different authors. An excellent recent review is found in the report by Price and Mostofi.[10]

Summary

Symptomatic renal angiomyolipomas unassociated with tuberous sclerosis are uncommon. Cases have been reported.

In contrast to some previous reports, clinically these tumors present symptomatically and are most frequently associated with hemorrhage. Certain roentgenographic features have been reviewed. Pathologically they are composed of mature adipose tissue, vascular components with variable size, shape, arrangement and structure, and smooth muscle in sheets of interlacing bundles.

Addendum

Since this paper has been completed for publication a paper has been published by Dr. Utz et al reporting 32 cases of renal angiomyolipomata. These cases were collected over a 50 year span. Twenty-three cases were found by surgical exploration and nine were found at autopsy. Four of these cases had previously been reported. It is presumed that these cases were covered in the review

of the literature. There were 23 women and nine men in the series. Of the 23 surgical patients, 21 had nephrectomy. Twelve of these cases had some degree of tuberous sclerosis.

Bibliography

1. Adelman, B. P.: Angiomyolipoma of the Kidney. Amer. J. Roentgenol. 95: 403-405, 1965.

2. Allen, T. D. and Risk, W.: Renal Angiomyolipoma, J. Urol., 94: 203-207, 1965.

3. Brody, H. and Lipshutz, H.: Concomitant Intrarenal and Pararenal Angiomyolipomas. J. Urol., 74: 741-746, 1955.

4. Khilnani, M. T. and Wolf, B. S.: Hamartolipoma of the Kidney; Clinical and Roentgen Features. Amer. J. Roentgenol., 86: 830-841, 1961.

5. Klapproth, H. J., Poutasse, E. F. and Hazard, J. B.: Renal Angiomyolipoma, AMA Arch. Path., 67: 400-411, 1959.

6. Love, L. and Frank, S. T.: Angiographic Features of Angiomyolipoma of the Kidney. Amer. J. Roentgenol., 95: 406-408, 1965.

7. MacDougall, J. A.: Renal Hamartoma Causing Intraperitoneal Hemorrhage, Brit. J. Urol., 32: 280-281, 1960.

8. McQueeney, A. J., Dahlen, G. A. and Gebhart, W. F.: Cystic Hamartoma (Angiomyolipoma) of the Kidney Simulating Renal Carcinoma. J. Urol., 92: 98-102, 1964.

9. Perow, M. L. and Gray, P. T.: Mesenchymal Hamartomas of the Kidneys, J. Urol., 83: 240-261, 1960.

10. Price, E. B., Jr. and Mostofi, F. K.: Symptomatic Angiomyolipoma of the Kidney, Cancer 18: 761-774, 1965.

11. Robertson, T. D. and Hand, J. R.: Primary Intrarenal Lipoma of Surgical Significance. J. Urol. 46: 458-474, 1941.

12. Rusche, C.: Renal Hamartoma (Angiomyolipoma): Report of Three Cases. J. Urol., 67: 823-831, 1952.

13. Taylor, J. N. and Genterr, K.: Renal Angiomyolipoma and Tuberous Sclerosis. J. Urol., 79: 685-696, 1958.

14. Tweedale, D. N., Daive, C. J., McDonald, J. R. and Culp, O. S.: Angiolipoleiomyoma of the Kidney, Report of Case with Observation on Histogenesis. Cancer, 8: 764-770, 1955.

15. Vasko, J. S., Brockman, S. K. and Bomar, R. L.: Renal Angiomyolipoma: A Rare Cause of Spontaneous Massive Retroperitoneal Hemorrhage. Ann. of Surg., 1961: 577-581, 1965.

16. Yekel, R. L. and Tesluk, H.: Angiomyolipoma of the Kidney. Bu'll. Masm Clinic, 15: 93, 1961.

17. Farrow, G. M., Harrison, E. G., Utz, David C., and Jones, D. R.: Renal Angiomyolipoma, Cancer Vol. 22: 564-570, 1968.

Millionth Woman Tested In A. A. G. P. Cancer Program

A million women have been tested for cancer of the cervix in the first four years of a nationwide cervical cancer detection program sponsored by the American Academy of General Practice. In the four years more than 5,000 doctors in 40 states have participated in what is described as the largest single research project in history.

Participating doctors discovered 2,000 cases of cervical cancer in the million examined and another 10,000 women with suspicious findings, requiring followup examinations. An integral part of the office detection program is the relay of each individual test result to the Public Health Service's Cancer Control Program branch in Washington, where it is computerized for further evaluation in relation to the total sample.

It is significant, reports the chairman of the Academy's Committee on Cancer, that of the million women tested, one-third were receiving their first examination for the disease.

The Psychologist as the Psychiatrist's Pathologist—A Rebuttal

A. Jack Turner, Ph. D., T. J. Michels, Ph. D.
Auburn University

In the March 1969 issue of *Journal of the Medical Association of the State of Alabama*, Drs. Eber, Ward and Ritchey published an article entitled The Psychologist as the Psychiatrist's Pathologist. The position taken by this article, and its assumptions, are questionable due to a failure to take into account current needs and professional trends. For example, in the State of Alabama there are approximately 15 full time mental health centers that call for a full professional mental health team (Psychologist, Psychiatrist, Psychiatric Social Worker, and Psychiatric Nurse), but these clinics have a total of three psychologists, no psychiatrists, and less than half the other team members needed. Not only are we unable to meet the existing treatment needs, the prospect of much improvement in the future is dim. Therefore, psychologists who are probably better trained, in psychological processes than are the other mental health team members, must be considered as independent mental health practitioners and not as a member of the lab team.

The article also fails to take into account national trends in the mental health movement which appears to be moving in the direction of giving psychologists autonomy in the diagnosing, treating and rehabilitation of patients with emotional and/or mental disorders. One example of this movement is that insurance carriers now make payments directly to psychologists for their services (dropping the requirement of a referral by a physician). Other notable indications of these trends are that the Veterans Administration rulings allow psychologists equal status in treatment (except in organic illnesses), licensing laws in approximately forty states regulate the practice of psychology as a separate entity, and psychological training institutes are reluctant to allow supervision of trainees and interns by psychiatrists. A further example is the following rights and privileges requested by the California State Psychological Association, in March 1969:

1) Joint admitting and discharge of patients in hospitals treating mentally ill patients;

2) Direction of psychotherapy, ward management, and other non-medical aspects of treatment for his own patients;

3) Full participation in staff conferences devoted to his patient's care;

4) Voting privileges and leadership opportunities in psychiatric departmental committees.

The title of the article and the description of the role of the psychologist assumes that the patient is suffering from some organic cause and effect disorder that is generally referred to as the Medical Model of mental illness. (*i.e.* A pathologist assumes pathology!) Recent evidence suggests that the medical model is non-preferred as the best framework for approaching mental disorders. In fact, a recent development entitled "Behavior Modification" has consistently reported treatment success approximating 90 per cent, whereas the medical model approach usually does not exceed 70 per cent recovery. The development of behavior modification, led by psychologists, is based upon the application of learning principles to maladaptive

Dr. Turner is Associate Professor, Psychology Department, Auburn University and Dr. Michels is Assistant Professor, Counselor Education Department, Auburn University.

behavioral patterns. If these promising findings continue, the roles suggested in the article could serve as a model for treatment with the roles reversed.

Several times in the article the author makes a point and then states that the validity of the statement is not at issue. The mere stating that a point is not at issue does not make it so. A case in point may well be one which the previous article failed to mention, that psychiatrists are expert interviewers.

A primary theme of the article involves the advantage of an accurate diagnosis. Accurate diagnosing of a patient assumes several questionable assumptions. First, it assumes reliability and mutual exclusiveness of the variables used in making the diagnosis, an assumption which is at best, unsubstantiated. Second, it assumes the usefulness of the diagnosis, either for treatment or research purposes, and again, to our knowledge, there is no specific treatment available for specific diagnostic catagories. Furthermore, research efforts using diagnostic catagories have not generally proven fruitful. The preoccupation of the former article with diagnosing causes one to speculate if some persons recognize the purpose of diagnosing.

Much of what the authors present is scientology and labology that attempts to make effective use of all team members, but with little awareness of the assumptions or implications underlying such an arrangement. It is our opinion that the separate professions charged with the responsibility of identifying, preventing, treating, and rehabilitating mental and emotional disorders would do their professions and the public a greater service by maintaining their independence as responsible autonomous professionals and avoid establishing lab teams that relieve one or more team members from his obligations.

Books Of Interest To Doctors and Patients

THE PILL (Facts and Fallacies About Today's Oral Contraceptives), by Robert W. Kistner, M. D., a Seymour Lawrence Book, Delacorte Press, New York—$5.95.

What is it? Is it a boon to all mankind or a deadly menace to morals and health? It has been accused of causing diarrhea and constipation, headaches, leg aches, hand numbness, feet coldness, apathy, jittery nerves, too much libido, too little libido, weight gain, weight loss, hair growth, hair loss.

And "no drug could do all of these things to some patients and nothing to others," insists Dr. Kistner, who once read in disbelief a magazine headline about him that read: "Dr. Robert W. Kistner of Harvard Medical School Startled his Cohorts at the American College of Surgeons by Stating that all Women over 40 Should be Dead." Nowhere in the article was there justification for the headline—but then, most people read only the headlines!

Here is a book that in 350 pages explores every facet of the subject and, while the author is neither a moralist nor a theologian, but a gynecologist, any book about The Pill must of necessity explore the charge that it "encourages sexual promiscuity, particularly among teenagers." And Dr. Kistner declares:—

". . . to conclude that the Pill is responsible for increasing sexual promiscuity in a world of nudity, pornography, alcohol, marijuana, and LSD borders on the ludicrous."

Between the Foreword and a valuable Glossary, the main body of the book is divided into four parts, captioned: "Contraception," "Effects of the Pill," "The Pill and Women's Disorders," and "Psychological, Social, and Moral Effects of The Pill." It is a book that may be substituted for a direct answer, when a physician is asked about "the facts and fallacies about today's oral contraceptives."

—W. J. M., Jr.

nursing care for cancer patients–

...a major concern for their families, *and* for their physicians. In a unique pioneering service, the American Cancer Society is deeply involved in finding a solution.

Recognizing the phenomenal growth of nursing homes—aware of the shortage of nurses—knowing the implications of the extended care benefits of Medicare—the Society has launched a dramatic educational demonstration project on cancer nursing for nursing home staff. Special emphasis is on colostomy irrigation, care of the laryngectomized patient, care of an ileal bladder, and emergency nursing. To achieve maximum application of this plan, a cadre of nurses is being trained by the Society to conduct cancer nursing courses in nursing homes throughout the nation.

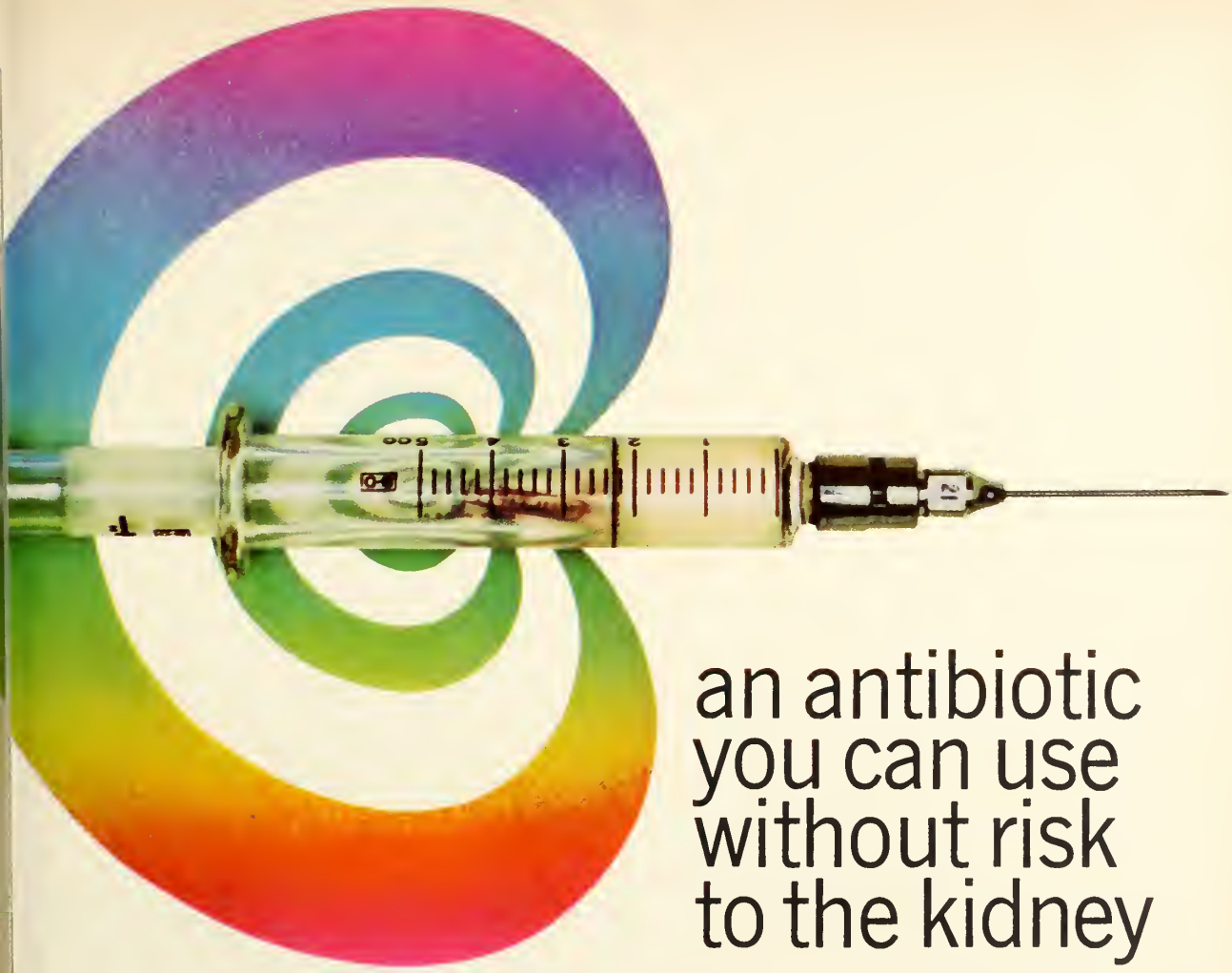
This endeavor has been warmly endorsed by the American Nurses Association and other professional organizations. We feel sure that such a program, bringing skilled nursing care to the bedside of the cancer patient, will be enthusiastically received by the medical profession.

AMERICAN CANCER SOCIETY®



THIS SPACE CONTRIBUTED BY THE PUBLISHER

AMERICAN CANCER SOCIETY ALABAMA DIVISION, INC.
1025 SOUTH 18th STREET
BIRMINGHAM, ALABAMA 35205



an antibiotic you can use without risk to the kidney

Polycillin-N®

(sodium ampicillin)

the penicillin you use like a broad-spectrum antibiotic

RESCRIBING INFORMATION. 11—1/2/69. For complete in-ormation consult Official Package Circular.

ndications: Infections due to susceptible strains of Gram-egative bacteria (including Shigellae, *S. typhosa* and other almonellae, *E. coli, H. influenzae, P. mirabilis, N. gonor-hoeae* and *N. meningitidis*) and Gram-positive bacteria (in-uding streptococci, pneumococci and nonpenicillinase-pro-ucing staphylococci).

ontraindications: A history of allergic reactions to penicillins cephalosporins and infections due to penicillinase-produc-g organisms.

recautions: Typical penicillin-allergic reactions may occur, specially in hypersensitive patients. Mycotic or bacterial su-erinfections may occur. Experience in newborn and prema-re infants is limited and caution should be used in treatment, ith frequent organ function evaluations. Safety for use in regnancy is not established. In gonorrheal therapy, serologic sts for syphilis should be performed initially and monthly for months. Assess renal, hepatic and hematopoietic function termittently during long-term therapy.

dverse Reactions: Skin rash, pruritus, urticaria, nausea, vom-ng, diarrhea and anaphylactic reactions. Mild transient ele-tions of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.

Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis—150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.

A.H.F.S. Category 8:12.16

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



Indications: For the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture.
Contraindications: Evidence of or a history of blood dyscrasia, in patients with active organic disease of the central nervous system, and the first trimester of pregnancy.
Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers; it is not known whether this can be injurious to the newborn.
Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.
Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weak

Flagyl®
brand of
metronidazole

simplifies vaginitis therapy

The effectiveness of Flagyl in *Trichomonas vaginalis* vaginitis has been so constant that use of less effective agents would seem to invite unnecessary failures. ▪ The simplicity, completeness and persistence of cures with Flagyl qualify it as the logical first therapeutic choice in trichomonal infections.

simple Ten-day treatment with Flagyl oral tablets has replaced a multitude of untidy douches, powders, creams and jellies.

complete Flagyl is the only medication available that is able to reach all the crypts, glands and cavities of the female urogenital system as well as reservoirs of reinfection in male trichomonas carriers.

lasting Flagyl eradicates resistant, deep-seated invasions of *Trichomonas vaginalis* and consistently produces cure rates above 90 per cent and often as high as 100 per cent in large series of patients. When the diagnosis is positive, Flagyl is positive.

ness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: In the Female. One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used,* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage *is reduced to two 250-mg. tablets daily during the ten-day course of treatment.* Do not use the vaginal inserts as the *sole* form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

Dosage Forms: Oral tablets . . . . . 250 mg.
Vaginal inserts . . . 500 mg.

G. D. SEARLE & CO.
Research in the Service of Medicine

941

Benadryl®

(diphenhydramine hydrochloride)

PARKE-DAVIS

Parke, Davis & Company, Detroit, Michigan 48232

56569



Drs. Wilbur And Rogers Differ On Future Of Medicine

(A TV Interview on Today Show)

EDWIN NEWMAN: Americans spend $54 billion a year on medical care and yet, a Presidential committee, after a lengthy study, has asserted that the present state of America's health services is so deplorable that it amounts to a national crisis. Now, we're going to examine the situation now with two eminent men of medicine, Dr. David E. Rogers, Dean of the Medical Faculty of Johns Hopkins University Medical School in Baltimore, who is severely critical of the way his own profession is functioning, and Dr. Dwight L. Wilbur of San Francisco who, as President of the American Medical Association, speaks for the most powerful organization in our health system.

Gentlemen, we'd like to deal with three basic questions: Is the crisis as serious as the Presidential committee says it is; if so, what are the causes; and what should be done about it.

Let's start with Dr. Rogers. What do you think is wrong, if you do indeed think something's wrong, with health care in the United States?

DR. DAVID E. ROGERS: I realize your three questions are a large order there, Mr. Newman, but I think we are in for serious problems. I think it really has to do more with the distribution of health care than anything else. I think all of us are concerned about the inequities of care for different population groups—particularly rural areas, urban ghettos. I think we are concerned about the maldistribution of doctors, of nurses . . .

NEWMAN: Is this a geograpical matter or an economic matter?

ROGERS: I think it's both. I think part of it has to do with geography in terms of where doctors locate, where our major centers are. I think our major concern—or, my major concerns are the non-system, if you will, that we have—the lack of organization of the health system, which makes it hard for a patient to know where to initiate his care and how to move into the system.

NEWMAN: Do you accept that there is a national crisis?

ROGERS: I think we're approaching one in terms of problems in this area, yes.

NEWMAN: What would you say about that, Dr. Wilbur?

DR. DWIGHT L. WILBUR: Well, Mr. Newman, I think a good deal depends on how you define the question. Certainly, for some people, one can say there is a crisis, particularly in terms of shortages of physician services in certain areas in the cities and in certain rural areas in this country, but in terms of a national crisis that we're used to such as in relationship to, let's say, the depression or what goes on at time of war, I don't think you can say there really is a crisis.

NEWMAN: Do the two of you agree on the size and nature of the problem, then? If you like, we won't use the word 'crisis'; let's say 'problem'. Are you in agreement on what the problem is, and how bad it is?

WILBUR: Well, maybe I might start off on that, if I may, and say I think basically the problem is that medicine has been such a great success that the demand for medical services has far outstripped our ability as a profession to render the service, and not only in terms of doctors and in terms of facilities, but in terms of financing the health care of 203 million Americans.

ROGERS: I in general would agree . . .

NEWMAN: Dr. Rogers?

ROGERS: . . . with this, yes. I think it has outstripped our capacity, and I think, as with many other elements in our society, nowadays, we really haven't organized the system well enough to deliver what we know how to deliver, which I think is a major concern, both to the consumer and for doctors.

NEWMAN: What about the profession itself, Dr. Rogers? Has it done what it should have done?

ROGERS: I would say not to the extent of its capabilities. I think, again, this could be said about many sectors of our society right now but that we're suddenly recognizing that we're well behind in terms of organizing the system in responsible ways for the consumer, for the patient.

NEWMAN: You said in a recent address, Dr. Rogers, that the physician has—I'm reading, I'm quoting—"has not met his responsibility to society and has not been trained to do so." What did you mean by that?

ROGERS: My recollection is that I was talking here about our—some of our failures to really involve the young physician in some of the social responsibilities that go with medicine. I think I was making the point that we've made, probably, the world's best bio-medical scientist out of our young physician, but that we've had—we have, in the process, kind of ignored the fact that he may have social responsibilities which extend beyond being just a scientist. Dr. Wilbur may want to comment, but I would like to come back to this point.

NEWMAN: Please.

WILBUR: Well, I think there's quite a bit of truth in what Dr. Rogers has said. Again, this brings us to the fact that there has been, really, a social revolution in this country in the last 20 years and that this has changed our society markedly, and with this change there has been an increasing demand for health care.

NEWMAN: Has the medical profession itself—and this is, I think, a general impression—deliberately kept down the numbers of people who are allowed to become doctors?

WILBUR: No. This is absolutely untrue. No.

NEWMAN: Not true?

ROGERS: I would say untrue, also, Mr. Newman. I think the point I wanted to make, if I could extend. . .

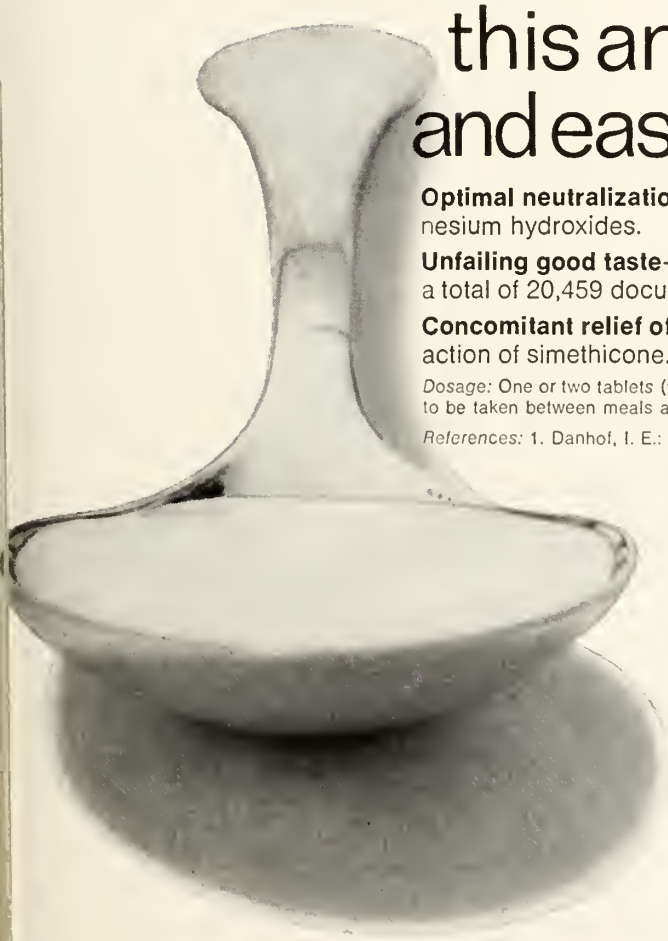
NEWMAN: Please.

ROGERS: . . . the one before, is that we now have such tremendous technology in medicine —let me use, as an example, the fact that where pneumonia used to cause a 20 per cent mortality, now with antimicrobials it causes less than one per cent in a young population group—but we have, I think quite appropri-

(Continued on Page 160)

the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization—provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste—confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[1]

Concomitant relief of G. I. gas distress—provided by the proven antiflatulent action of simethicone.[2]

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References: 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. 93:467 (Sept.) 1966.

Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109

(Continued from Page 158)

ately, concentrated with the young physician on how to make this diagnosis and deliver that type of care, feeling that the hand-holding features of the old-time practitioner were less important than being able to deliver the proper drug at the proper time.

So I—my point being that I think we've concentrated on biomedical science for a good reason, but now we're moving into another phase of medicine where. . .

NEWMAN: Which is what? The social organization of it?

ROGERS: . . . Where clearly the social organization of it is a big and important responsibility for us.

NEWMAN: Well, in that connection, let me ask about a specific thing. The Presidential committee that made the report cited as one point worth thinking about that the infant mortality rate in the United States was the lowest in the world 20 years ago and now we rank 15th. We used to be best and now we're 15th. Now, Dr. Wilbur, who is to blame for that, if anybody is?

WILBUR: That's a very hard question to answer, because it's not purely a matter of medicine; it has to do with many other factors in life, including housing, food, education, the willingness of the patient—the woman who's going to have the baby—to see her physician on time, during her pregnancy, and this is largely a matter of education. This infant mortality rate is discussed and debated a good deal because the statistics of one country to another will vary, and in some of our cities where there are very good medical facilities, infant mortality is surprisingly high, which indicates that the facilities alone are not the important thing—that people have to want to use these facilities—they have to learn that they should use them earlier than they do.

NEWMAN: Well, this is part, then, of the social organization question, is it, Dr. Wilbur?

WILBUR: Yes, it is.

NEWMAN: Social application . . .

WILBUR: That's right. And not purely the result of something that's not being done by doctors.

NEWMAN: Dr. Rogers, you have said—this, I think is a quote—it may be a paraphrase—that the entrepreneurial system of medical practice is obsolete. What do you mean by 'the entrepreneurial system' and why do you think it's obsolete?

ROGERS: Well, I was—it's been my feeling that the solo practice of medicine, the individual physician functioning quite in isolation from other physicians—that this day is obsolete, that, again, our technologic knowhow is so great I think we must organize a system so that groups of physicians, or groups of physicians working with other kinds of health professionals, can form a consortion of some sort to which the patient comes. They could develop—to deliver the kind of care we really can to human beings nowadays, it can't all rest in the mind of one man, and I think consequently the solo practice of medicine is on the way out and probably should be in terms of our—the knowledge we now possess about how to deliver proper care.

NEWMAN: Dr. Wilbur?

WILBUR: Well, I'm going to take a little different view than Dr. Rogers on that. Unquestionably, there is a trend toward group practice and whenever one has a complicated situation, obviously a group is necessary, but so many illnesses nowadays can be handled by a single physician and—in solo practice—and a physician in solo practice can use his associates and has available the same facilities as a group does in terms of what we call the 'allied health professionals', that he can do a very effective job. And there are many people who really prefer to go to a single physician in solo practice and I think this will always be the case.

NEWMAN: Do you have a reply to that, Dr. Rogers?

ROGERS: I do. I have enormous respect for Dr. Wilbur; we've worked together on a num-

ber of things. But I think this is an issue on which we would separate. I think not only for the reasons that I mentioned, but, as an educator, I realize that it is increasingly difficult to attract the young man to that kind of isolated existence and I think, in terms of what we want out of physicians today, their continuing education is critical, which means, I think, they should have continuing daily contact with other physicians. I think, in terms of the kinds of social situations they desire and the sorts of lives that they wish to lead, that the solo practice of medicine is phasing out, and that we ought to accept this fact, and decide, what can we do with our present knowhow to replace it with a system which is as good or better.

I fully agree with Dr. Wilbur's point about the—that one human being really has to have one physician responsible for him. And here, I think we would feel very similarly. One cannot be taken care of by committee. One doctor has to take responsibility for a human, but I think groups of physicians are going to be able to support each other in ways that will further their education and make the medical system better for our population.

WILBUR: Well, I might point out, if I may, that such physicians in solo practice really do have this opportunity because most of them belong to the staff of a hospital, or they're in a professional building or set up where they have available consultation with others in the field of . . .

NEWMAN: Dr. Wilbur, as Dr. Rogers said, this is a point on which the two of you . . .

WILBUR: Yes—obviously going to diverge.

NEWMAN: Gentlemen, is there any case, do you think, for having a health service in this country, something like the one the British have and some other countries have?

WILBUR: Well, let me answer that by saying, no. I think the level of practice in this

(Continued on Page 162)



country is such that we really are the envy of the world, despite the fact that our system is not a perfect one, and I think this is indicated by the fact that some 19,000 foreign medical graduates take an examination to try to get into this country every year, for further training and for experiences in this country.

NEWMAN: Dr. Rogers?

ROGERS: Well, I would answer it somewhat differently, in that I think we must develop some delivery system. If your question is, should this be a nationalized health system, the commission of which Dr. Wilbur was a member pointed out that really the job is too big for government to do alone; I think it's going to take the cooperative efforts of all of us to design a system where the patient knows where he should enter the health system, how it—where he should move as his illness grows more complex. But I do think we must develop some overall system for the delivery of care, both for the efficiency of physicians and so that patients can use it properly.

NEWMAN: Got about thirty seconds left, Dr. Wilbur . . .

WILBUR: Well, I'd like to comment on that . . .

NEWMAN: . . . would you like the last word?

WILBUR: . . . I think we ought to have multiple systems, because this country is so diverse, with its rural and urban problems, that to have a single system would be inadvisable. And the other advantage of diversity is that you, by experience, gain knowledge as to how best to deliver the health care that we have available.

NEWMAN: Thank you very much, Dr. Wilbur . . .

ROGERS: I would share that view—that it should be a multiple.

NEWMAN: . . . and thank you, Dr. Rogers.



Mrs. Chenault Becomes Auxiliary President On Epic Date In History

The inaugural address of Mrs. John M. Chenault of Alabama as president of the Woman's Auxiliary of the American Medical Association, made on the epochal date of the APOLLO XI launch, before the annual meeting of the Auxiliary held in New York City, follows in full:

INAUGURAL ADDRESS

MRS. JOHN M. CHENAULT

July 16, 1969

For the past year the date July 16, 1969, has been circled on my calendar as a date of importance in my personal life . . . I realized that it would be a date on which I would receive the highest honor that can be given to the wife of a physician in these United States—that of being installed as President of this great Auxiliary . . . It was also a date on which I knew it would be necessary to assume responsibilities beyond my limited capabilities—yet I was equally certain that with the help of the 90,000 members of our organization and through the grace and guidance of God Almighty, the job could be done.

Only recently has it become known that this date, July 16, 1969, was also to become an epic date in the history of the world, not because of anything happening in this room, but because it is the date which marks the greatest milestone yet accomplished in the story of man's conquest of space—the day on which the flight was to begin which hopefully will put the first man on the moon . . . Not long ago, a writer of science fiction was widely quoted as saying that this flight of APOLLO XI and subsequent events of this summer may well be the means of insuring the survival of the human race as we reach out into the heavens, literally finding new worlds to conquer, new planets to make our own, new knowledge of the universe . . . Whether or not we agree with this estimate of the future, we cannot fail to be aware that the days in which we are now privileged to live are days full of challenges to man's intellect and imagination, days filled with opportunity for advancement of every kind—scientific, intellectual, social, economic.

Yet talk of the survival of the human race is nothing new to those of us who are so closely involved with the medical profession—this has been the absorbing and consuming goal of physicians everywhere since time immemorial . . . This is the ideal to which our husbands and those doctors before them have dedicated their lives . . .

Thus the events of this one day bring into sharp contrast two factors which must affect each of us—first, rapid changes in outlooks and attitudes, and second, the eternal and everlasting values which will never completely change . . .

Perhaps the greatest certainty in life is the certainty of change . . . We have witnessed changes in communication, in transportation, in living standards, in respect for authority . . . We have been troubled by revolts on college campuses, violence within our cities, conflicts between racial groups . . . We have been concerned about apparent changes in the moral code of our nation . . . We have been grieved by a seemingly endless, undeclared war . . . We have fought saliently and sometimes vainly to slow our nation's progress toward becoming a welfare state . . .

There have been sweeping changes also in medical practice, both in the advances in the art and science of medicine, and also in involvement of third parties in the delivery and financing of health care . . .

(Continued on Page 167)

WHAT'S SO WEAK ABOUT THE WEAKER SEX?

OFTEN... HER LOWER G.I. TRACT



Psycho-abdominal Distress: Frequently Female

Women aged 15 to 45 appear to be more prone than men to bloating, cramping pain of stress-related intestinal disturbances such as irritable or spastic colon.[1,2]

Frequently Recurrent

In the experience of many physicians, women are more likely to reappear time after time with repeated complaints of lower G.I. distress.

Requiring Definitive Therapy

Often needed is therapy adequate to control both the somatic and the emotional components of psycho-abdominal complaints.

Definitive Dual Therapy

'Milpath' contains a proven synthetic anticholinergic useful for relieving hypermotility, spasm, and hypersecretion of the gastrointestinal tract.

In addition, 'Milpath' provides a time-tested tranquilizer for mild but effective anti-anxiety action.

With Flexible Dosage

- 'Milpath'-400 (meprobamate 400 mg. + tridihexethyl chloride 25 mg.) Usual adult dose: 1 tablet *t.i.d.* and 2 at bedtime.
- **When less tranquilization is required: 'Milpath'-200 (meprobamate 200 mg. + tridihexethyl chloride 25 mg.)**

Wallace Pharmaceuticals/ Cranbury, N.J. 08512

gently but firmly

MILPATH®

(meprobamate + tridihexethyl chloride)

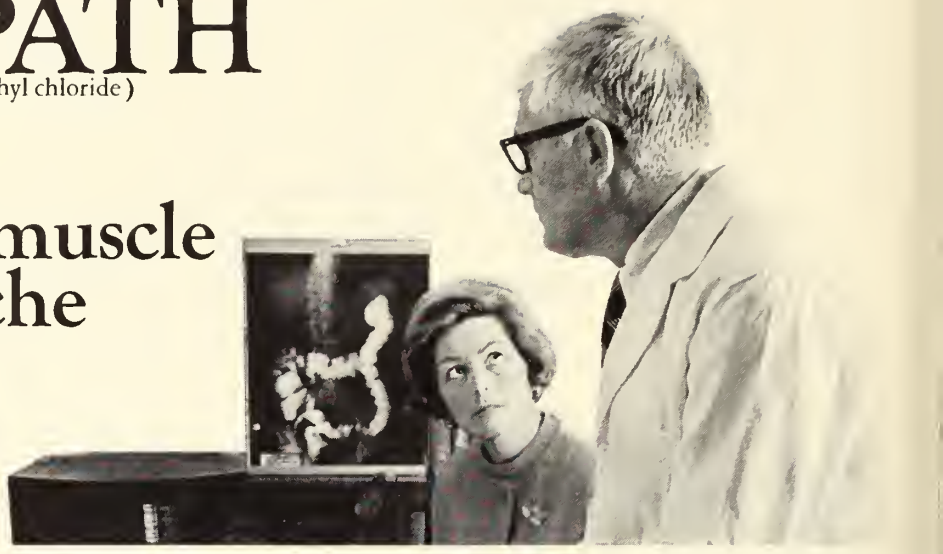
relaxes smooth muscle and psyche

Please see the following page for brief summary of prescribing information.

Gently but firmly MILPATH®

(meprobamate + tridihexethyl chloride)

Relaxes smooth muscle and psyche



Usual Adult Dosage

One 'Milpath'-400 tablet, three times a day at mealtimes, and two at bedtime. For greater anticholinergic effect, two 'Milpath'-200 tablets, three times a day at mealtimes and two at bedtime. Doses of meprobamate above 2400 mg. daily not recommended.

Indications

Useful in organic and functional disorders with hypersecretion and hypermotility of G.I. tract, especially when accompanied by anxiety, neurosis, or tension states. Should be used as an adjunct to all other therapeutic measures.

Contraindications

Tridihexethyl chloride: Urinary bladder-neck obstructions, e.g., prostatic obstruction due to hypertrophy; pyloric obstructions because of reduced motility and tonus: organic cardiospasm (megaesophagus); glaucoma; possibly in stenosing gastric or duodenal ulcers with significant gastric retention.

Meprobamate: Previous allergic or idiosyncratic reactions to meprobamate.

Precautions

Tridihexethyl chloride: Use cautiously in elderly males (possible prostatic hypertrophy).

Meprobamate: Carefully supervise dose and amounts prescribed. Consider possible dependence or habituation (reported occasionally after excessive use), particularly in severe psychoneurotics, alcoholics, ex-addicts. Withdraw gradually (one or two weeks) after excessive dosage for weeks or months to avoid recurrence of pre-existing symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching; rarely, epileptiform seizures, more likely in those with CNS damage or latent convulsive disorders). If drowsiness or visual disturbance occurs, reduce dose and advise against activity requiring alertness (driving, machinery operation). Effects of excess alcohol may be increased. Grand mal seizures possible in persons with both petit and grand mal. Prescribe cautiously in small amounts to patients with suicidal tendencies. Prescribe with caution to patients with known sensitivity to compounds of similar chemical structure, e.g., carisoprodol.

Side Effects

The following side effects of components may occur with 'Milpath'.

Tridihexethyl chloride: Severe effects rare on recommended dosage. Anticholinergic effects: dry mouth (fairly frequent at oral doses of 100 mg.), constipation or "bloated" feeling. Possible: tachycardia, dilation of pupils, increased ocular tension, weakness, nausea, vomiting, headache, drowsiness, urinary hesitancy or retention, dizziness.

Meprobamate: Drowsiness, sometimes with ataxia, usually controlled by decreasing dosage, occasionally with aid of central stimulants (e.g., amphetamine). Rarely, allergic or idiosyncratic reactions (usually after one to four doses); in mild form: itchy, urticarial or erythematous, maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever, transient leukopenia, and one fatal bullous dermatitis (after meprobamate and prednisolone) reported. More severe, very rare hypersensitivity: fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (one fatal), anuria, anaphylaxis, stomatitis and proctitis. Treat symptomatically (e.g., epinephrine, antihistamines, possibly hydrocortisone); stop and do not restart the drug. Isolated agranulocytosis, thrombocytopenic purpura, one fatal aplastic anemia reported, but only in presence of known toxic drugs, porphyric symptoms reported but relationship not established. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation reported by one observer. Fixed drug eruption with meprobamate and cross reaction to carisoprodol reported.

Suicidal attempts may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Excessive dosage has led rapidly to sleep, then reduction of vital signs to basal levels. Empty stomach, and if respiration becomes very shallow and slow, cautiously give CNS stimulants (e.g., caffeine, pentylenetetrazol, amphetamine); also pressor amines if indicated.

Supplied

In two strengths:

'Milpath'-400: Yellow, scored tablets.

'Milpath'-200: Yellow, coated tablets.

Before prescribing, consult package circular.

References

1. Harrison, T. R., et al.: Principles of Internal Medicine, Fifth Edition, New York, The Blakiston Division, McGraw-Hill Book Company, 1966, p. 1019. 2. Bockus, H. L.: Gastroenterology, Second Edition, Philadelphia & London, W. B. Saunders Company, 1964, Vol. II, p. 729 et seq.

(1928A01J)

(Continued from Page 163)

But through all these changes, certain institutions and ideals have remained basically unchanged . . . Just as it is necessary to recognize the effect of change and adapt to it, so is it also necessary to hold on to and preserve those institutions which are unchanging . . . Only then can we come to know that change need not mean chaos; disappointment need not bring disaster; frustration need not lead to failure . . . Only then can we find strength to lead or faith to follow, whichever may be our destiny.

What are some of these institutions in which we can still take pride? Closest to our hearts is the institution of the family, the basis of our society . . . Since the dawn of history, human beings have lived in families of one sort or another, and no society has succeeded long in dissolving the family or in displacing it . . . No effective case has yet been made for an alternative to the family as an essential element of human evolution . . . We hear a great deal about the breakdown of the family unit, yet statistics show us that 92 per cent of all Americans either have married or will marry.

The delights of family life—and its hurts and heartaches—will very likely be the same in the future as they have in the past . . . Frank McGee, in discussing tomorrow's family says, "Within the family there will be a companionship, that can exist nowhere else . . . There will continue to be communication in the deepest sense, a knowing when to offer praise and reproof, and insight into needs . . . Procreation and desire for continuance of the line will be unchanged . . . The concern over illness and security, the tension of domestic finance, the fascination of shared experiences and of learning together will still be there . . . All these things will continue to provide the intangible strengths of family life."

Of equal importance to us, is the preservation of our form of government, according to the Constitution a democracy within a republic . . . Let us realize that, with all its oft-mentioned faults, ours is still the nation which most nearly guarantees individual freedom to its citizens . . . We are the most privileged people in the world today . . . But let us also remember that with each privilege goes an equal responsibility . . . Each of us is obligated to exercise leadership in whatever way we are able and to work to elect and support men of integrity to the halls of government at every level . . . We of the medical family must take an active interest in government, for surely government is taking an active interest in us . . . We must be informed in Public Affairs, for the public is becoming increasingly informed about medical affairs.

In difficult times such as these in which we live, it is easy to lose faith in ourselves . . . Unfortunately, some physicians and their wives have seemingly lost faith in the AMA, paying more attention to the written and spoken words of outsiders than to the facts presented by their leaders . . . No organization is perfect, but let it be said that the leaders of the American Medical Association have, through the years, done what they could as well as they have known how to do it . . . And in our zeal to do better, let none of us be guilty of tearing down and casting out all that has been done in the past, just because some of it did not work out right . . . Instead, let us hold onto those things which are good, those things which have contributed to progress, and build upon them for the generations that will follow us.

And always have pride in your sponsoring organization—whether it be national, state, or local . . . As we work with our medical societies, let us always be ready to stand up and be counted as we speak out with pride for those things that are *right* with American medical practice.

Another source of pride should be our own auxiliary, which is constantly growing, both in numbers and in influence . . . Sometimes that growth is slow enough that we become discouraged, but if we will look back over

the 47 years of our existence, the progress is evident . . . With the prospect of a sounder financial basis as we implement the change in dues voted by this body last year, we should be able to render even greater service to our communities and to the medical profession . . . But we must make a special effort to keep our membership level high, to narrow the gap between membership in the auxiliary and in the respective medical societies . . . We must tell our story well, and then we must live our story faithfully, so that our organization will increase in attractiveness.

It has become traditional for your incoming president to outline in her inaugural address all the "new" things she hopes can be accomplished during the ensuing year . . . This year, we must break with tradition for I have very little "new" to suggest . . . In fact, you don't even have a "new" president, just the same one you have been looking at and listening to all during this convention.

It is a part of human nature to remember best two types of things—those that are *first* and those that are *most recent* . . . The first year that I had a national job was in 1955-56 . . . In those days it was customary for each new president to announce a "Theme" which was used throughout the year in program planning, in speeches, even as a slogan put on every item of mail going out from headquarters . . . In 1955-56 that theme was "Active Leadership in Community Health." . . . It seemed an important concept then—it seems equally important now.

Herein lies the true strength of the auxiliary . . . Here we have the gift of service which only we can give . . . Because of our unique relationship to the medical profession, our opportunities for cooperation with other organizations, our contacts within the communities in which we live, we are better able than any other group of people to foster health education, to work toward improvement of health facilities, to discover health needs and seek to meet them—in short to work side by side with our husbands and our sponsoring medical societies to raise the level of health care for all the people.

So first and foremost, I would urge you to continue your "Active Leadership in Community Health."

The most recent national emphasis was that which we began to promote formally during this past year—placing the "Accent on Youth." . . . Your Board of Directors considers this emphasis sufficiently important that a new program extension committee on Children and Youth has been authorized . . . You are being asked to continue the Accent on Youth during the coming year, broadening it to include, wherever possible, a strengthening of the family unit.

Population estimates show that there are presently in the United States 17,000,000 young people in the 15-19 year age bracket and 25,000,000 between 20 and 29 years of age. The offspring of the post-World War II baby boom are the young marrieds of today, beginning to establish their own families, beginning to raise their own children, beginning to take over the leadership of our nation . . . These young people, for the most part, have a great desire to fulfill their roles in society better than their parents have done . . . They are perhaps more idealistic than practical in their estimation of what our world should be like . . . Yet they can accept the certainty of change better than can we, their elders . . . They have grown up in an era of unprecedented scientific advances and have been participants in the resultant transformation of society.

In a recent issue of "Pace" magazine, a group of college students put it this way, "Our generation is the first to feel that uncontrollable change is an asset and not a disaster . . . That is the adventure of our age . . . In spite of the frustration and uncertainty, we want to use all our resources, all our energy and imagination . . . We are a part of the future, a part of hope."

As an auxiliary, and as individuals, our task and our challenge is to commit ourselves

to assisting our young people, as well as our mature citizens, whether they be married or single, rich or poor, of whatever race, or creed or color, to reach their goals, to use their energy, resources, and imagination to solve the problems of our times, particularly in the field of health.

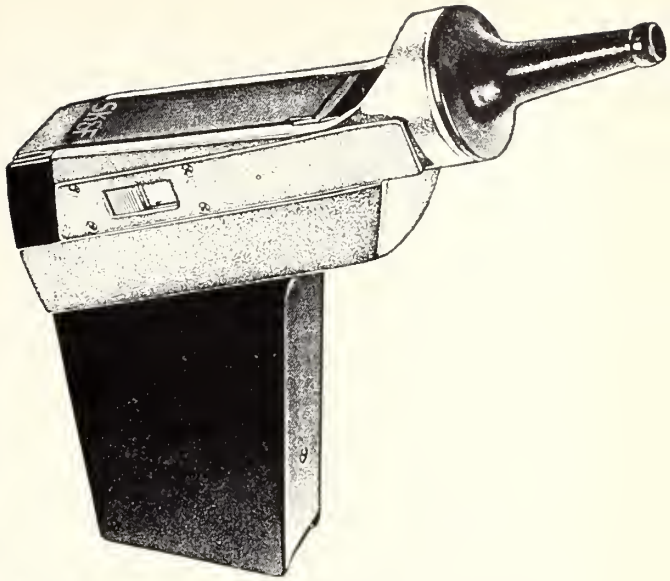
Let us study the health resources of the area in which we live, let us evaluate the human resources with which we have to work . . . Then let us direct our energy toward achieving better health conditions, using our imagination in developing projects and programs which will meet the health needs of our communities . . . Where there is ignorance let us encourage education; where there is misunderstanding let us provide information; where there is poverty, let us foster opportunity . . . Let us offer "Active Leadership in Community Health, with the Accent on Youth."

You have heard the tried and true rule for becoming a leader—"Find a group of people who are going somewhere and get in front of them." . . . In assuming the presidency of this auxiliary, I have done exactly that, for you are a group destined to go a long, long way . . . Perhaps not in distance as measured by miles, but certainly in depth as measured by the work and influence of each individual member.

We used to say "The sky's the limit." . . . Now, with man's conquest of space, we can say there is no limit to what this auxiliary can do, God willing, as we labor together with the medical profession for the preservation and enrichment of life through better health for All Americans, and indeed, for all Mankind.

If They're Likely To Recover

The Southern Pacific Railroad has donated its old Sunset Hospital to the University of Texas M. D. Anderson Hospital and Tumor Institute, Houston, which plans to use it as a center for rehabilitating cancer patients who show a good chance for recovery.



See more, do more with the new Hotchkiss™ Otoscope

A revolutionary new instrument rather than an improvement over existing equipment, the Hotchkiss Otoscope employs the principles of modern optics to give you a brighter, clearer, more informative view of the ear canal and tympanic membrane. It's also more versatile than ordinary otoscopes—you can use it for diagnostic or operative procedures without making any changes. Yet the five-ounce Hotchkiss is lighter, easier to handle and carry, and every bit as durable as instruments that offer you less.

See for yourself. Clip and mail the coupon, and our Representative will call for an appointment to show you the new Hotchkiss Otoscope in your office.

SK&F Smith Kline & French Laboratories

Smith Kline & French Laboratories E-30 B
1500 Spring Garden Street
Philadelphia, Pa. 19101

I would like your Representative to call for an appointment to show me the new Hotchkiss Otoscope.

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

HOPE "Virus" Infects Everyone Who Goes Aboard--- Esprit De Corps

By William A. Daniel, Jr., M. D.

I trust that the *New York Times* has accepted the fact that HOPE is not a government enterprise, but is rather a project that began during the Eisenhower administration. There was a feeling at that time, shared by the President, that people - to - people could do a great deal in helping the underdeveloped countries as well as improving our image elsewhere in the world. Our foreign aid programs have run into as much criticism and the people-to-people idea was the one which was proposed.



Dr. Daniel

Dr. William B. Walsh, an internist in Washington was captivated by this idea, and talked Ike into permitting HOPE to use hospital ship consultation. This hospital ship had seen service in the Korean War and was actually the first one in which helicopters brought wounded soldiers to the ship's deck.

So with funds available from donations by the public, drugs donated by pharmaceutical companies and various other manufacturers, the HOPE set sail to Indonesia, and on to Saigon. On this voyage the ship stayed in a place one to three months, treated patients and learned the lesson that, although for the individual patient this is excellent, very little continuing benefit results.

So after that, on subsequent voyages, the ship has gone to a country and stayed approximately ten to eleven months and concentrated more on teaching than treatment. Now of course it is impossible just to teach without treating and many thousands have been admitted aboard HOPE, for medical or surgical services, immunization, etc. HOPE has been to Indonesia and South Vietnam. Then it went to Peru, to Ecuador, to Nicaragua, Columbia, South America, Guinea, West Africa, and then to Ceylon. It will go to Tunisia about mid-September of this year.

I once saw a notice in a medical journal about HOPE, wrote them, and the reply said that doctors spent months of their time and were not paid, that they were given transportation and board and room while in a host country. Because it was two months I thought I could not go and so did not fill out the application. Next year I received a letter from them that they did need a pediatrician in Ecuador and would I go. I felt that I could not be gone for two months but finally Bob Parker, Buddy Noland and other pediatricians said to go ahead and they would work for me.

This was all I needed plus the approval of my wife, and by sheer coincidence, Jack Till, from Montgomery, and I went at the same time. Dan Haygood in Montgomery, had become interested through my talking about the project. And as it turned out he went two months before we did, so the three of us from Montgomery, really went to Ecuador and had an absolutely fabulous time.

In addition there is a Dr. Ted Kirkland, an ophthalmologist in Birmingham, who has been. And last year Sterling Edwards, a cardiac surgeon, went to Ceylon on the HOPE. Now I have heard that Jack Kirschenfeld from Montgomery was going and I really do not know if he went or not, but if you are interested in that I am sure that a telephone call would let you know. After Ecuador the next year I was asked if I would help in the pediatric department.

HOPE had become complicated and one man had great difficulty in keeping track of

everything; so I said yes I would help out with the pediatric department, which I have ever since. Actually though what I do now is: about five of us, each in a different specialty in medicine and dentistry, go to the next country that the ship will visit. The ship will be in one spot, but we fly to the next one, and perform a survey.

I have visited Ecuador and Peru, Columbia, South America, Ceylon, and now this year I was in Tunisia. Usually our surveys take about two weeks and while there we try to find out what the facilities are, what the medical needs are. In each country we try to check their needs, facilities, decide in which area the host country's medical personnel are interested, what we think they should be interested in, and also specific differences.

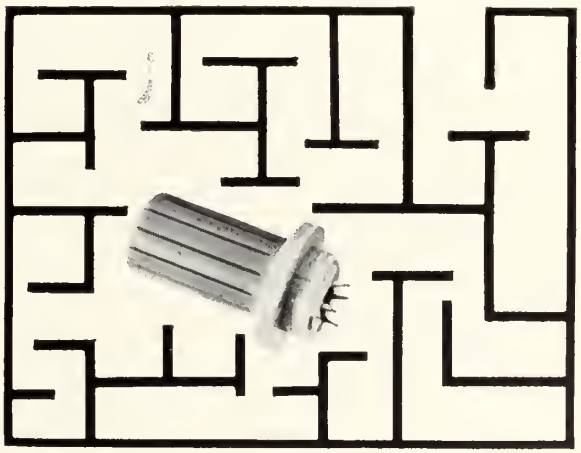
Having been on the State Board of Trustees of our own association, I have always been very interested in the medical organization of the various countries and they have indeed varied and I think that we could learn a lot of lessons, both good and bad about associational organization and problems. In evaluating the needs as well as what we can do for our country, I think one must keep in mind that the HOPE is really a small medical center. The non-doctors work full ten months on the ship and there is a chief of staff and usually two or three other fulltime doctors in administrative rolls. Other than that it is sort of like a medical center, in that we teach nursing, laboratory technicians, X-ray technicians, how to take EEGs, EKGs, how to do physiotherapy, etc. Hopefully by providing teaching in these areas, all of which are needed everywhere, we found that we can make a lasting impact on a country's paramedical personnel. For example in Ceylon the ordinary PAP smear, which is taken for cancer, was rarely done, because there was not a trained technician in the country to read them.

The doctors were very well educated in Ceylon, but the laboratory facilities were extremely handicapped. So while HOPE was there they trained two technicians in cytology, each of which is going to go ahead and take two more and continue on in this process until hopefully many PAP smears can be done. We try to do the same thing with our medical rotators. Each doctor serves two months and lives aboard the ship.

This is an absolutely fabulous thing because once again it is almost like doing internship or residency, except that there are rarely emergency calls, you are not bothered by a telephone, you are so far from home that you cannot worry about income tax or anything else, and you are thrown together with a very fine group of doctors from all over the United States in every specialty. I think that this is one of the greatest things about HOPE.

In addition there is an 'esprit de corps' all the way through the ship that is very diffi-

(Continued on Page 174)



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST

(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES

A Division of American Cyanamid Company, Pearl River, New York

473-9

Convalescing . . . but still a long way to go. Anxiety can make it even longer.

Convalescence following medical or surgical procedures may be almost endless to an anxious patient. And, indeed, anxiety with some patients actually retards progress—for example, by inducing insomnia and reducing cooperation.

As physicians have found during nearly 15 years of widespread use, Equanil may be a beneficial part of aftercare. It helps relieve anxiety and tension, thus often aiding your primary therapy.

Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

EQUANIL®
(meprobamate)

Wyeth®

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.



(Continued from Page 170)

cult to define and we call it the "HOPE virus" because it seems to inoculate everyone who goes aboard the HOPE and we all feel a kinship to each other. Now in our survey team too, we try to find out what the local medical school is doing, what its curriculum is in each specialty, and how we can tie in with the curriculum for the medical students. We are very anxious to have contact with medical students which we bring aboard the ship and occasionally also teach in shore hospitals. We think it is good for the students not only to get up their ideas, but many of these countries' positions are predominantly European trained in specialties and still have the ideas that the attending man or professor is always right, and the students are not even allowed to question anything or do much on their own.

So, we like to break this down and show them what the American system is. We also usually have what we call a counterpart, that is a local physician in each specialty. For example, in pediatrics, a pediatrician of the host country would give up his practice for a month and come work for the HOPE with the rotating pediatricians. It is the same in other specialties. When you do this you get to make very close friends, you learn an awful lot from the man who is there and hopefully he will learn something from you. Now we often have students aboard the HOPE from the United States. Since I am at the medical center here, of course, I am always anxious to have someone from Alabama aboard the ship. Actually we have had two students who served with the HOPE in Nicaragua, both of whom thought that it was an absolutely wonderful experience. We had one boy from Selma, Bud Ehlert, whose father is a surgeon in Selma, on the Ceylon rotation. If anyone knows Bud they have only to ask him about it to see how enthusiastic he is. This year a senior medical student, Ronald Merrell, from Birmingham, is going to Tunisia on an official elective from the school and work with HOPE. To show you that there are other benefits, there is an organization called the Caduceus Club, here to which many of the doctors of Alabama belong and we wish more of them did. Dr. Carey Phillips in Birmingham, is the current president of the organization.

The Caduceus Club has taken as one of its functions, to help send medical students for teaching and perhaps research work, both in and outside the United States. Funds are limited, but when it is possible they will do this. One girl has been sent to South America on a non-HOPE project, but this time Ronald Merrell is sponsored by the Caduceus Club, which will pay his way to and from Tunisia. We would hope that he may give a report of this trip to the doctors of Alabama. Many people have asked why I and others go on the HOPE. I do not think any of us can define it. Perhaps if we basically got down to it we would say that we wanted to do something ourselves, that we wanted to show our country did not need to spend a lot on foreign aid on dubious products and that by giving something of one's self it seems to be a little bit better than giving just money. I do not look upon myself as a do-gooder at all. So many times when the HOPE first comes into a country, the local communist party does all it can to discredit the program, but by the time it ends, the people have seen that actually we came there to help them and we are interested in them, we have their full support. It is awfully hard for them to believe that HOPE is supported by the people and not the government.

Opportunity to practice in quiet rural Nebraska, 1100 population, plus large trade area. Facilities available with financial backing. Golf, hunting, fishing, and boating. North Central Accredited school and six churches. Progressive modern town.

Contact

ROGER A. PENTZ, D. D. S.

Box 317

Arapahoe, Nebraska

When it's more than a bad cold



your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

348-8


SPAIN
ARIZONA
FLORIDA
ENGLAND

Our travel-pak for summer cold and allergy sufferers.

Novahistine LP can speed your patients on their way, by providing prompt and continuous relief from the symptoms of summer colds and allergies. These continuous-release tablets contain a vasoconstrictor-antihistamine formulation that goes to work rapidly and lasts for hours. Even when nasal congestion is caused by repeated allergic episodes, the convenient twice-a-day dosage of Novahistine LP makes it easy for most patients to enjoy relief all day and all night. When symptoms are severe, a third dose of one or two tablets may be safely given. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana.

Novahistine® LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)





around the state

Vital Statistics

NEW MEMBERS

Clarke County

Bowling, Robert Shaw, Jr., b 26, mc Ala. 56, sb 57, P. O. Box 428, Jackson, Alabama 36545. (Transfer from nonmember to member)

Lauderdale County

Ambrose, Melton Crosby, b 36, mc University of Tennessee 1962, recip. Tenn. 1968, 416 North Seminary Street, Florence, Alabama 35630.

Mobile County

Nichols, Edward Tyler, b 38, mc Ala. 1962, sb 1963, 181 Louiselle Street, Mobile, Alabama 36607.

Weaver, Charles Daniel, b 32, mc Louisiana State University 1959, recip. Louisiana 1966, 1710 Center Street, Mobile, Alabama 36604.

CHANGE OF ADDRESS

Calhoun County

Laws, Henry Latham II, present Anniston to 411-D East Ninth Street, Anniston, Ala. 36201.

Franklin County

Keel, Hollis Cecil, present Red Bay, to 3216 Monte Doro Drive, Birmingham, Ala. 35216.

Houston County

Atkinson, Gordon Allen, present Dothan to 1912 Fairview Avenue, Dothan, Ala. 36301.

Jackson County

Hodges, Emmett Julian, present Scottsboro to 915 South Broad Street, Scottsboro, Ala. 35768.

Jefferson County

Carmichael, James Donald, present Birmingham to 2016 South Tenth Avenue, Birmingham, Alabama 35205.

Davis, Thomas McLellan, Jr., present Birmingham, to 800 Clinic Lane, Bessemer Clinic, Bessemer, Alabama 35020.

Ott, W. Rodney, present Birmingham to 7832 2nd Avenue South, Birmingham, Ala. 35205.

Pappas, Dennis George, present Birmingham to 2016 South Tenth Avenue, Birmingham, Ala. 35205.

Sox, Joe Howle, present Birmingham to 2508 Chatwood Road, Birmingham, Ala. 35226.

Mobile County

England, Francis Tillman present Mobile to 3167 Dauphin Street, Mobile, Ala. 36606.

Sewell, James Wesley present Mobile to 1720 Center Street, Suite 101, Mobile, Ala. 36604.

Montgomery County

Page, Thomas N. present Portland, Oregon, to 14150 Southwest Bull Mountain Road, Tigard, Oregon 97223.

Morgan County

Guice, John Roland, present Decatur to 1222 Somerville Road, Decatur, Ala. 35601.

Johnson, Jimmy Robert, present Decatur to 1222 Somerville Road, Decatur, Ala. 35601.

DEATHS

Cullman County

Culpepper, Rufus A., Cullman, Alabama. Deceased June 23, 1969.

Jefferson County

Argo, John R., Birmingham, Alabama. Deceased.

Cailleteau, Janice, 1919 7th Avenue South, Birmingham, Ala. Deceased June 5, 1969.

Hargis, Albert S., Jr., Fairfield, Alabama. Deceased June 1, 1969.

Harris, Esau A., Bessemer, Alabama. Deceased June 14, 1969.

Mobile County

Winsor, Carlton W., Mobile, Alabama. Deceased.

* * *

Saccharin . . . This new preparation, to which Fahlberg has given the name saccharin, is not a carbon hydrate, but an aromatic derivative of anhydrous orthosulfaminbenzoic acid; and is characterized by its excessively sweet taste, being 280 times sweeter than cane sugar. It will never be substituted for sugar in household economy, because it possesses no nourishing properties; but for sweetening sour wines, and more especially for making palatable the food and drink of diabetic patients, it will prove very efficient. A curious fact is that ants, flies, wasps and bees will not touch it. Saccharin is also an antiseptic and has been repeatedly used by Fahlberg in cattarrh of the bladder.—Therap. Monatshifte, 1880, 10-Rundschau, Dec. 1, 1887. (Reprinted from Virginia Medical Monthly, January 1888).

Montgomery County

Cowles, A. D., Ramer, Alabama. Deceased June 14, 1969.

Tuscaloosa County

Click, Gustav Neri, Tuscaloosa, Alabama. Deceased.

MOVED

Marion County

Reeder, James Lendon—moved to Artesia, New Mexico.

TRANSFER

Garner, Mabry E., Fairfield Works Medical Center, Fairfield, Ala. 35064, from nonmember to member Jefferson County Medical Society.

CHANGE OF SPECIALTIES

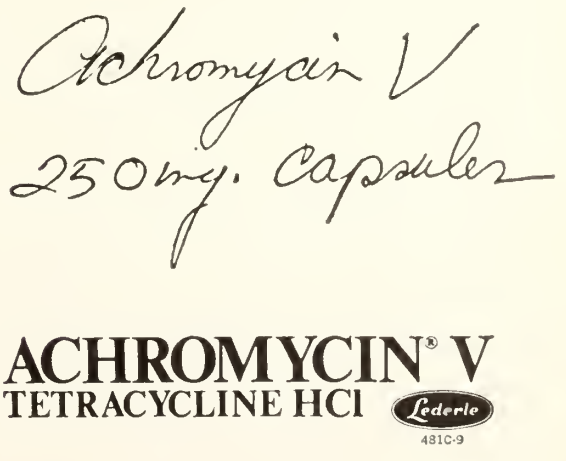
Ott, W. Rodney, 7832 2nd Avenue South, Birmingham, Ala. ENT.

NEW TELEPHONE NUMBERS

Kirklin, J. W. 934-5167

Lightfoot, P. M., Jr. 269-1486

Woodfin, M. C. 265-8502



Dead At 96, Dr. Harris Leaves Two Sons In Active Medical Practice

Dr. Esau A. Harris, who had practiced medicine 61 years when he retired a decade ago, is dead at the age of 96.

At the time of his retirement a feature story in *The Birmingham News* quoted his estimate of 3,000 babies delivered over those years, including his two sons, both of whom survive him in the active practice of medicine in Jefferson County.

One of those sons, Dr. Edward A. Harris, a pediatrician, is currently chairman of the Jefferson County Board of Censors, who served through the midsummer as acting county health officer, and the other, Dr. Reuben R. Harris, is in general practice and surgery.

The late Dr. Esau Harris held one of the few M. D. degrees from the University of the South, Sewanee. His years of practice spanned three distinct eras in the realm of medicine, and he used three methods of transportation to reach his patients—first in a saddle, then in a buggy, and finally in a car.

Born of Welsh parents in Frostburg, Md., April 8, 1873, he lived as a boy in Ohio and Colorado before moving with his father, a mine superintendent, to St. Clair County, Ala., in 1890. He remembered that he himself as a boy had dug coal in the mines and clerked in a commissary.

Both sons obtained their baccalaureate degrees from the University of Alabama and their M. D. degrees from Washington University in St. Louis.

Dr. Edward Alun Harris, the eldest, is currently Associate Clinical Professor of Pediatrics, Medical College of Alabama, in addition to private practice in pediatrics. He is Pediatrician to Juvenile and Domestic Relations Court of Jefferson, member of the Advisory Board of the Family Court, on the Courtesy Staff of St. Vincent Hospital (where he was Chief of Pediatrics for seven years), a past president and on the Attending staff of Children's Hospital; on the Consulting staff of the Baptist Hospitals; on the Courtesy Staff of South Highlands Infirmary and Carraway Methodist, and on the active staff of University Hospital.



Dr. and Mrs. Esau A. Harris



Dr. Harris with his two sons, Dr. Edward A. Harris and Dr. Reuben R. Harris.

Married to the former Esther Barrett in 1935, there is one son, Edward Alun Harris,

Jr. His biography appears in *Who's Who in the South and Southwest.*

The younger son, Dr. Reuben Rhys Harris, served his country through the war years in this country and in the China-Burma-India theater of operations, entitled to wear the Asiatic-Pacific Medal with two battle stars.

Dr. Reuben Harris was married in 1941 to Julia A. Thiemonge, and they have four children: —Reuben Rhys, Jr., David C., Alison Julia, and Lailah Caroline. Listed in *Who's Who in Alabama*, he is a past president of the Exchange Club, the Five Points West Branch; was for five years Instructor in Surgery, Medical College of Alabama, and is on the Active Staff of Birmingham Baptist Hospitals.

Besides the two sons, the senior Dr. Harris is also survived by his widow, the former Lailah Alverson, and they celebrated their Golden Wedding anniversary in 1960.

A brother of Dr. Esau Harris also practiced medicine in St. Clair and Jefferson Counties until his death in 1924. He was Emrys Charles Harris, who received his M. D. degree from the Medical College of Alabama in Mobile in 1906. His widow, the former Ellen Spears, and son, Emrys, Jr., are presently residents of Miami, while his daughter, Mrs. Elizabeth Harris Harrison, resides in Owings Mill, Md.

* * *

The use of ultrasonic vibrations may soon make cataract removal minor surgery. Current standard surgical procedure requires an incision of 21 millimeters; and suturing requires from four to eight stitches. The average recovery period calls for a week's stay in the hospital and from four to six weeks of home recuperation. The ultrasonic method allows the patient to be back to business in a few days, under the technique evolved by Dr. Charles D. Kelman, New York City.

* * *

A Blind Telephone Operator

A small sensor worn on the index finger is enabling a blind man to work a telephone switchboard in New South Wales, Australia. The battery-powered, light-sensitive probe consists of a small fingertip unit and a power pack about the size of a pound of butter. When the probe detects light, it produces a sharp audio signal. The blind operator runs his finger along the switchboard and the probe spots the light coming from a particular key. It also distinguishes between pulsating and steady lights on the board. The New South Wales Electricity Commission designed the probe and alarm especially for a blind employee assigned to operate a switchboard at one of its power plants. The commission currently employs four blind operators, but, thanks to the inexpensive seeing eye device, intends to hire more.

Not just a motel
it's a Guest House

. . . with 171 handsome rooms designed for your comfort and convenience. A center-of-everything location including Birmingham's University of Alabama Medical Center . . . making The Guest House a favorite of Doctor's wives and in-town outpatients. Superb dining, dancing and nightly entertainment. Come stay with us often.

THE RESTAURANT
THE PLAYROOM • CYPRESS ROOM
CONVENTION FACILITIES



The Guest House
MOTOR INN

PHONE 324-8653
18TH ST. &
10TH AVE., SOUTH
BIRMINGHAM, ALABAMA

"Where the Action Is!"

Mobile County---A Child Centered Program To Prevent Tuberculosis

Throughout this past school year, a major co-operative program in school tuberculin skin testing was held in Mobile County—through the joint planning of the County Board of Health, George W. Newburn, Jr., M. D., Health Officer; and the Mobile County Board of School Commissioners this effort was made.

The following chart information shows the final statistical results of the testing program and will serve as a model for effecting future skin testing activity as explicit information is now available noting areas and specific schools with higher reaction rates. This will aid in developing priority testing areas in the future. It should be noted that our program for this year covered all public schools in Mobile County as well as private or parochial schools as requested. Grades one, two, three, four, and eight were included:

	Number
Enrollment in grades noted	33,870
Children tested	25,273
Tests read	23,531
Tests not read	1,742
Total tested including school employees	26,476
Total read including school employees	24,734
	Percentage
Per cent of tested who were read	93.1
Per cent not read	6.9
Per cent of total enrollment tested	74.3
Per cent of total enrollment read	69.5

It should be noted that letters from the School Board informed parents of the reasons for the testing as well as the date. Only those children with signed parental consent were included in the program on the testing date. The Mobile County Health bus was employed at the schools and served to keep the flow of children at a rapid pace without disrupting school activities. It was not at all uncommon to complete a school of 600 in about one hour's working time.

Final Results of Program by Grade:

Group	No. Read	Reactors	Percentage
1st	4562	27	.59
2nd	4880	29	.59
3rd	4766	30	.63
4th	4826	33	.68
8th	4497	65	1.4
School employees	1203	102	8.5
Overall	24,734	286	1.2

These figures indicate a reaction rate for all grades at 0.78 per cent. To make this determination, a reading of 8 millimeters or more with the Mantoux gun was considered positive. Readings of 0 to 4mm were read as negative, and those in the 5 to 7mm range were considered doubtful. These individuals were retested with specific PPD and Battey antigen. Upon reading of these

two tests, the larger reading was accepted and the individual followed.

No program, no matter how extensive in skin testing, is of value unless individuals return for interpretation of test results and are included in a comprehensive follow-up of tuberculin reactors. Some reactors elected to visit their family physician. In some cases only chest x-rays were made with limited family follow-up. This included limited recommendations of TB chemoprophylaxis.

However, for those individuals who came to the Board of Health, a comprehensive program was initiated. The Public Health clinician, Dr. Life Barnard recommended a 14 x 17 chest x-ray film for all reactors. Those with films read as "Negative" were instructed to accept an Isoniazid regimen for one year. This recommendation is based upon extensive Public Health Service studies demonstrating the value of chemoprophylaxis in reducing the risk of developing active tuberculosis disease in the future.

For those positive reactors who were referred by the nurses to the Board of Health clinics, a comprehensive program was instituted. Of the 102 school employees who were positive, 87 received x-rays and were placed on INH prophylaxis. In addition 42 of their associates were skin tested and 6 out of 7 of those reacting were given a chest x-ray and prescribed INH for a year. This year's program also calls for at least two additional chest films for those with negative chests. As adults about half indicated some knowledge of exposure to an individual they felt did have active TB at some time in their past.

Among the school children, the following of 159 reactors concluded with 406 associates being skin tested. Of this number 279 were negative and 127 were positive. Of this latter group 112 were placed on INH chemoprophylaxis. Seventy-two sources of infection were identified. Of this figure three active cases were uncovered, one was returned to treatment, and thirteen previously known inactive cases were returned for medical evaluation to include x-ray, sputum, and in some cases, renewed medication.

	Reactors	On Rx	Percentage
School employees	102	87	85.3
School children	184	159	86.4
Overall	286	246	86.0

As a major achievement of this program, fourteen diagnosed cases of primary tuberculosis (x-ray evidence) were uncovered among the school children. This yield appears quite high when considering that these 14 children were discovered among the 159 reactors followed. All 14 are under chemotherapy. Ten source cases have been identified at this writing with continued contact work in the home being pursued.

Mobile County now has a larger gathering of epidemiological information regarding areas of infection. It is intended to make use of this in the future. This will hopefully result in continued success in casefinding and pursuit of those with TB or at special risk of developing tuberculosis.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph. D., Director

Alabama Department of Public Health Laboratory Combined Division Report for May, 1969

April 1969

	No. Specimens received
General Bacteriology	2,104
Virology	246
Parasitology	2,115
Enteric Bacteriology	313
Fluorescent Microscopy	5,181
Tuberculosis	5,059
Micology	78
Milk and Dairy Products	5,210
Water	3,602
Sea Foods	46
Syphilis Serology	33,798
Special Serology	1,099
Metabolic Diseases	24,830
Cytology	2,666
Chemistries	281
Miscellaneous	985
Total Number of Specimens Received	87,613



The Bradley Center --- for the problems of living

An all new homelike open psychiatric residence on a lovely five-acre tract, centrally located within the community, providing a comprehensive range of continuous services, including in-patient, day care, and outpatient treatment. Each patient participates in an extensive and intensive treatment program, based almost exclusively upon multiple psychotherapeutic encounters. These include individual psychotherapy, group psychotherapy, the nursing milieu, occupational therapy, recreational therapy, topical small group discussions, and other group activities in the Center, as well as in the community, depending on individual needs and interests. Medications are prescribed when appropriate.

Any individual may be admitted who, in the opinion of the medical staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible family member.

Accredited by the Joint Commission on Accreditation of Hospitals.

Leonard T. Maholick, M. D.
Medical Director

Maj. Gen. (ret.) Howard Snyder
Administrator

THE BRADLEY CENTER, INC.
2000 Sixteenth Avenue
Columbus, Georgia 31901
Area Code 404 324-4882



introducing an anticostive* antacid

*Avoids constipation.

an antacid formulated especially for the constipation-prone patient

- Gelusil-M has been formulated to help avoid constipation in these patients: hospitalized/bedridden/debilitated/sedentary/pregnant/elderly/on a bland diet/on anticholinergic-antispasmodic drugs/when straining at stool should be avoided.
- Magnesium content helps maintain intestinal fluid volume and motility.
- Some patients may develop loose stools while taking Gelusil-M. This condition is usually dose-related, and usually responds to dose reduction.

introducing new

GELUSIL®-M*

each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate
250 mg. aluminum hydroxide (Warner-Chilcott)
200 mg. magnesium hydroxide

*U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

†Avoids constipation.

See next page for prescribing information ▶

GELUSIL–one name to remember...and a dosage form for every patient.



Gelusil®-M Liquid

especially for the constipation-prone patient

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

the universal take-along antacid

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquid

when constipation is not a problem

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)—or more—between meals and at bedtime, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey

GM-IN-92-4C



The Month in Washington

From the Washington Office
American Medical Association

Washington, D. C. — The Internal Revenue Service plans to audit the federal income tax returns of physicians and other health practitioners who have received more than $25,000 a year in medicare and medicaid payments.

Plans for the special audit were disclosed by IRS Commissioner Randolph W. Thrower at the first of a series of public hearings the Senate Finance Committee is holding in its investigation of the rising costs of the two government health care programs. He said the Department of Health, Education and Welfare had agreed to require intermediary insurance carriers to use physicians' social security numbers on reports of payments under the program in the future.

Finance Committee Chairman Russell B. Long (D., La.) estimated "possibly as many as 10,000" had been getting upwards of $25,000 a year under the programs. Thrower said the initial audits would be for 1967 and would be limited to those receiving more than $50,000.

Long said that the investigation of the committee's staff so far showed "widespread abuse, and fraud, as well as lax administration."

Robert M. Ball, social security administrator, reported his investigators had looked into more than 700 possible fraud cases under medicare. He said more than 300 of these cases were still in some stage of inquiry, and that 14 had been turned over to the Justice Department for prosecution.

"But these should not be taken as a reflection on the 200,000 doctors participating in medicare," Ball said. He added a bigger problem than outright fraud were "cases that don't quite become fraud."

HEW Undersecretary John G. Veneman told the committee that the Nixon Administration wants congressional authority to stop medicare payments to doctors who overcharge, use inferior supplies or engage in fraud.

"Under present medicare law, there is no authority for the program to deny reimbursement to a licensed practitioner, who has demonstrated a clear pattern of fraud, repeated overcharging of the program or the use of supplies which are inferior or harmful," Veneman said.

"We are recommending authority . . . to discontinue future reimbursement and to put all parties on notice to this effect where on the basis of clear evidence, a finding is made that this is justified by reason of such abuses."

Commenting on the hearings, Dwight L. Wilbur, M. D., president of the American Medical Association, said that the vast majority of physicians serving medicaid patients are not overcharging for their services.

"Most physicians," Dr. Wilbur said, "are acting honorably and with utmost restraint. Fortunately, very few M. D.'s participating in medicaid are guilty of overcharging and otherwise exploiting the program. Such exploitation by a minuscule minority was unavoidable. . . .

". . . The medical profession is making a great effort to identify and weed out dishonest doctors who betray their oath as professional men serving the public. We have been successful in this search, but a few physicians remain who still are not identified. We shall search them out and expose

them, for the good of the entire profession."

Meantime, HEW issued a regulation limiting the fees paid by states to physicians, dentists and other health practitioners under medicaid.

Under the regulation, a state's medicaid payment to a physician for a service will be limited, with one exception, to the 75th percentile of the customary charge—the maximum customary fee of 75 per cent of the physicians in the area.

If a state has been paying more than the 75th percentile of the customary charge, it must not exceed the medicare level, about the 83rd percentile. A medicaid official said that only two states may have to roll back their fees, but declined to name them.

After July 1, 1970, states may request permission to increase physicians' fees above the 75th percentile if two conditions are met:

1. The average percentage increase requested above the 75th percentile on January 1, 1969, may not exceed the percentage increase in the all-services component of the Consumer Price Index (adjusted to exclude the medical component) or in an alternate index designated by the Secretary of Health, Education and Welfare.

2. Evidence must be clear that the providers and the states have cooperatively established effective utilization review and quality control systems.

The new fee regulation also requires states to revise their medicaid plans to include descriptions and details of their payment structures. A state that wishes to revise its payment structure for practitioners' services or change the payments authorized under it may not do so until the proposed changes have been approved by the Secretary of Health, Education and Welfare or his representative.

States that begin their medicaid programs after July 1, 1969, must arrange their payment structures so that fees do not exceed the 75th percentile of customary charges.

HEW estimated the regulation would result in a saving of $65 million in the first year.

Despite a strong protest by the American Hospital Association, HEW discontinued the overhead medicare-medicaid percentage allowance paid to hospitals, extended care facilities and other institutional providers. It was two per cent for non-profit and one-and-one-half per cent for proprietary institutions. The action was effective July 1, 1969.

Another new medicaid regulation requires states to provide periodic health screening, diagnosis, and treatment for all eligible youths under 21 years of age, effective July 1, 1969.

HEW also established a new classification of institution—called intermediate care facility—eligible to receive federal contributions for the care of aged, blind, or disabled recipients or public assistance is covered in another regulation. This should reduce costs of medicaid by allowing states to relocate substantial numbers of welfare recipients who are now in skilled nursing homes in lower costs institutions, HEW said.

* * *

Dr. Roger O. Egeberg, who has been dean of the School of Medicine, University of Southern California since 1964, was selected to be the new Assistant Secretary of Health, Education and Welfare for Health and Scientific Affairs after a five-month delay.

President Nixon nominated Dr. Egeberg after HEW Secretary Robert H. Finch "reluctantly and regretfully" withdrew his unannounced but widely-publicized selection of Dr. John H. Knowles, director of Massachusetts General Hospital, Boston. Finch said that "the protracted and distorted discussion" about the appointment during the five months the post had been vacant "resulted in a situation in which he (Knowles) would not be able to function effectively in this critical position."

The news media—press, radio and television—generally assigned the opposition to

Dr. Knowles to conservative members of Congress, led by Senate Republican Leader Everett M. Dirksen, and to the AMA.

Throughout the public controversy before the appointment, the AMA confirmed its comment to a short statement that it had suggested several names to Finch for the post and that the Association "favored the appointment of someone who would represent the broadest scope of medicine and would not be too closely oriented to any one segment of medicine or the health field." Knowles was not one of the physicians on the AMA list.

A few days after the nomination of Dr. Egeberg, Dr. Dwight L. Wilbur, the AMA President, said:

"During the last five months the American Medical Association has been identified repeatedly as a force opposing appointment of Dr. John H. Knowles as Assistant HEW Secretary for Health and Scientific Affairs.

"We held our silence during the last months of nationwide publicity because we agreed with Secretary Finch to make our suggestions to him and then say no more. We did that. The Knowles protagonists obviously did just the opposite . . .

"In a true sense, we never opposed Dr. Knowles. But we did not support him because we had alternative recommendations."

Those recommended by AMA for the position, Dr. Wilbur said, included:

—Dr. W. Clarke Wescoe, former Chancellor of the University of Kansas, "who withdrew soon after because of personal reasons."

—Dr. Richard S. Wilbur, Palo Alto Clinic, Chairman of the Council of the California Medical Association, and former Chairman of the Board of California Blue Shield, "who happens to be my nephew, a fact which complicated the situation, but who AMA felt was a well-qualified man for this position.

—Dr. John R. Hogness, Dean of the University of Washington School of Medicine, "who serves in the AMA House of Delegates, at high level in the association of American Medical Colleges, and who has many other distinguished achievements."

The AMA commended the selection of Dr. Egeberg. In a telegram to Finch, Dr. Wilbur said:

"We look forward to a productive relationship with you and Dr. Egeberg in advancing the health care system for the benefit of all the American people. There are many complex factors involved that will call for the wholehearted dedication and contribution of all in the medical profession and in government."

"We believe Dr. Egeberg will be able to bring about the necessary close coordination between government and private sectors in the health care system," Dr. Wilbur said in a supplementary statement. "This is vital to constantly advance and expand the ability to provide quality health care for all Americans."

Dr. Egeberg, 65, is a large, bluff man of Norwegian stock who demonstrated a sense of humor at his first news conference. He is a member of the AMA and a diplomat of the American Board of Internal Medicine. Generally considered a moderate liberal on health matters, he served on several advisory commissions during the Kennedy and Johnson Administration and on the state level in California. One of his major interests has been health care of the poor and he arranged for the USC medical school to be the medical consultant for the neighborhood health center in the Watts district of Los Angeles.

At his first news conference in HEW, he classified delivery of health care as almost the department's number one problem. He said medicare now is "rather well established" in solving a problem. But medicaid, he said, "has run afoul of a number of things, and I don't know that one can blame any one person or any group for this."

A member of the army medical corps in World War II, he was personal physician and aide-de-camps to General of the Army Douglas MacArthur, 1944-45.

NORGESIC

(orphenadrine citrate, 25 mg., aspirin, 225 mg., phenacetin, 160 mg., caffeine, 30 mg.)

non-narcotic analgesi



For musculo-skeletal pain,

try Norgesic first...
8 of 10 patients probably won't need anything stronger

Norgesic offers predictable relief in approximately 80% of patients with painful musculo-skeletal disorders. It provides *both* effective analgesia and relief of associated muscle spasm. Norgesic works quickly, usually producing a high level of analgesia within two hours, and relief is sustained for four hours or longer.

For the relief of acute mild to moderate pain associated with musculo-skeletal disorders, try Norgesic first...eight of ten patients probably won't need anything stronger.

Indications: Symptomatic relief of acute mild to moderate pain of musculo-skeletal origin.

Contraindications: Due to the mild anticholinergic effect of orphenadrine, Norgesic should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcers, prostatic hypertrophy, obstructions at the bladder neck, achalasia (megaesophagus), myasthenia gravis or in patients known to be sensitive to aspirin, phenacetin or caffeine. Do not use propoxyphene (Darvon®) concurrently.

Warnings: USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the childbearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

Precautions: Recent studies have indicated that prolonged excessive use of phenacetin may result in nephrotoxicity. Caution should therefore be exercised when administering Norgesic to patients with renal insufficiency. It should also be used with caution in patients with tachycardia.

Adverse reactions: Side effects of Norgesic are those usually associated with APC or mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, mental confusion in the elderly, mild central excitation and occasional hallucinations. These mild side effects are usually eliminated by reduction in dosage. One case of aplastic anemia, with no established causal relationship, has been reported.

Dosage and administration: Adults—1 to 2 tablets 3 to 4 times daily.

For more detailed prescribing information, see Package Circular or PDR.

NORGESIC®

(orphenadrine citrate, 25 mg., aspirin, 225 mg., phenacetin. 160 mg., caffeine. 30 mg.)

non-narcotic analgesic

Riker Laboratories, Northridge, California 91324
Div. Dart Industries Inc.

Sponsors of Riker Service—
the complimentary classified service for physicians.

MEDICAL MEMORANDA

Music is proving a major communications medium with the mentally ill in Alabama, Kate Harris reports in The Birmingham News, citing particularly the work in this field by Dr. Geneva Folsum, wife of Dr. James C. Folsum, director of the Tuscaloosa Veteran's Administration Hospital, a psychiatric facility.

* * *

The newest cigaret additive, Chemosol, may become a *must* ingredient. This substance sharply reduces or eliminates the supposed cancer-inducing benzo(a)pyrene content of cigaret smoke, according to an article in the *United States Tobacco Journal.*

* * *

Diabetes, heart disease, epilepsy and alcoholism are equated under the general heading of "medical illness" as the cause of "an unknown percentage of highway crashes" in *The Journal of the Kansas Medical Society.* Other facets of the highway-death problem discussed in the article are the "crash-worthiness of the modern automobile," "the role of the driver in causation," "seat-belt injuries," and "measures to control highway deaths and injuries."

* * *

Without qualification, doctors are being widely blamed for the high cost of health. What the profession needs is wider publicity for such incidents as that in Jacobi Hospital, New York City, where all 45 pediatricians banded together to urge their low-income patients not to pay the clinic fees. Holding that the fees were hard on patients not quite poor enough for help from Medicaid, the doctors threatened a walkout if the hospital tried reprisals. Result: an income-related fee schedule lower for most patients. (Medical Economics).

* * *

PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. MASA members having knowledge of practice opportunities or wishing to relocate their own practices are urged to communicate with the Placement Service. For further information: write Mr. Emmett Wyatt, Executive Assistant, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama 36104, or Telephone 263-6441.

Locations Wanted

General Practice—

Age 44, Medical College of Alabama, 1967, seeking associate practice in town of 12,000 plus population in central or south Alabama. LW-1

Age 56, Georgetown University 1938; seeking solo, group or associate practice, with general surgery. LW-2

Age 52; University of Chicago 1950; seeking group, industrial, institutional or student health position. LW-3

Age 38; University of Oklahoma, 1955; seeking associate, institutional or industrial practice; in town of 10,000 plus population; interest in surgery. LW-5

Age 28; University of Tennessee, 1965. LW-7

Age 27, Medical College of South Carolina, 1966; seeking location in Gadsden area or in southern part of state in town of 5-7,000 population; available July 1, 1971. LW-7/1

Age 38; Medical College of Alabama, 1957; seeking location in south Alabama. LW-7/2

Age 60, University of Arkansas 1932, seeking location for general or industrial practice. Available May 1969. LW-7/3

Age 42; Medical College of Alabama 1957; seeking location in central Alabama, near Montgomery. LW-7/4

Age 34; University of Tennessee 1964; seeking associate practice. LW-7/5

Internal Medicine—

Age 36, Medical College of Alabama, 1963; seeking solo, group, or associate practice. LW-8

Age 34; Hahnemann Medical College 1959; Board eligible, National Board; seeking solo, group, or associate practice. Available immediately. LW-11

Age 35; University of Tennessee 1958; Board certified; seeking group, industrial or institutional practice. LW-12

Age 37, Duke University, 1956; Board certified, seeking group, associate, or institutional practice. LW-13

Age 33; University of Miami 1962; Board eligible; National Board; seeking solo, group practice, hospital practice, or industrial practice. Available July 1969. LW-13/1

Age 31; Medical College of Georgia 1963; seeking location for practice of internal medicine-cardiology. Available 1970. LW-13/2

Neurology—

Age 32, Medical College of Georgia, 1964, seeking assistant or associate, or institutional practice. LW-14

Age 31; Harvard 1962; Board eligible; National Board; seeking solo, group or associate practice. Available July 1969. LW-15

Age 30; Medical College of Alabama 1962; Board eligible; National Board; seeking solo, group, associate or institutional practice. Available January 1969. LW-16

Age 29, Indiana Univ., 1964; Board eligible; seeking assistant or associate practice in city of over 100,000 population; available July 1, 1969. LW-17/1

Obstetrics-Gynecology—

Age 35, Vanderbilt University, 1950. Board eligible. LW-18

Age 49, University of Nebraska, 1943; Board certified, seeking group or institutional practice. LW-19

Age 34, Medical College of Virginia, 1961, Board eligible, seeking group or associate practice. LW-20

Age 33; University of Illinois, 1964; seeking associate practice. LW-21

Ophthalmology—

Age 33; St. Louis University, 1962; seeking solo, or associate practice; available July 1, 1969. LW-21/1

Otolaryngology—

Age 32, University of Pennsylvania 1962, seeking associate practice. Available April 1970. LW-21/2

Age 35, University of Miami 1959, seeking location in city of 150,000 plus population. Available August 1970. LW-21/3

Psychiatry—

Age 52, Chicago Medical School 1939; Board eligible; seeking group or institutional practice, preferably near Gulf Coast. LW-22

Pediatrics

Age 30; Tulane University 1964; seeking associate practice in south Alabama in city of 20,000-90,000 population. Available September 1969. LW-23

Radiology

Age 28; Northwestern University 1964; completing radiology residency. Available July 1971. LW-24

Surgery—

Age 33; University of Missouri, 1961; seeking group or associate practice. Available January 1969. LW-27

Age 38; Emory University, 1956; Board eligible, seeking group, associate, or institutional practice. LW-28

Locations Wanted

(Continued)

Age 36, Indiana University 1961; Board eligible; seeking practice in city of 100,000 plus population. Available July 1969. LW-31/1

Age 37, University of Paris 1961; seeking group or institutional practice in city of 80,000 plus population. Available July 1969. LW-31/2

Age 48; Marquette University 1943; Board eligible; seeking institutional practice in east Alabama. Available July 1969. LW-31/3

Age 31; St. Louis University 1963, American Board certified; seeking associate practice. LW-31/3

Age 48; University of Pennsylvania 1950; Board eligible; seeking solo or group practice. LW-31/4

Age 31; Medical College of Alabama 1963; American Board certified; seeking associate practice. Available July 1970. LW-31/4

Age 36, Emory University 1959, Board certified, seeking associate practice. Available September 1970. LW-31/5

Urology—

Age 30; Louisiana State University, 1963; Board eligible, seeking associate, or group practice. LW-32

Age 31, Chicago Medical School 1963, seeking associate practice in Montgomery. Available July 1970. LW-32/1

Student Health—

Age 40, University of Oklahoma 1955, seeking institutional practice. LW-33

Physicians Wanted

Special Openings—

Specialist in the following fields: Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practitioners. 58-bed fully accredited general hospital with 91-bed addition recently completed. Modern new office space available. PW-20

Pediatrician, Internist, and ENT specialist to join a well-established group practice in a community of 40,000 in East Alabama. The community has a 125-bed accredited hospital, 32-bed extended care facility. Good transportation on interstate with quick access to metropolitan area. Will pay travel expense for interview. PW-20-1

Opportunity for ENT, Internal Medicine, and Orthopedic Surgery practitioners to join partnership at clinic located in city of 38,000 population in trade area of 150,000 population in northeast Alabama. PW-20/2

Position for full-time industrial practice at textile plant with 2,400 employees at Decatur, Alabama. PW-20/3

Internists, Board-certified or eligible. One needed now and another in 1 or 2 years. For early partnership with internist in south Alabama city of 40,000 plus population. New office building adjacent to 181-bed hospital. Practice largely hospital in-patient and Cardiology. PW-21

Opportunity for a Board certified or eligible surgeon to be associated with a Board surgeon in city of 150,000 population. PW-21/1

Opportunity for physician interested in joining a progressive public health tuberculosis control program working in Birmingham, Jefferson County. Provide outpatient medical services and some administrative duties. Fringe benefits and salary open. PW-22

Obstetrician-Gynecologist—

Excellent opportunity for a trained Ob-Gyn man who would join a three-man partnership practice in city of 30,000 population located in southwest Alabama. Salary is proposed for the first 12 months, a limited partnership to begin at the end of twelve months, and full partnership to begin at the end of 24 months. PW-25

General Practitioners—

Opportunity in town of 4,000 population in trade area of 50,000 population, located within 100 miles of two metropolitan areas in south Alabama. Industrial and farming area. 44-bed hospital. Office space and equipment available in new building with another physician. Several churches, schools, and service clubs. PW-1

For community of 1,500 population located in south Alabama near city of 12,000 population. Hospitals located within 25 miles. Office space and equipment available. Farming, cattle and textile industries in the area. Several churches and school. Civic clubs and golf courses. PW-1-1

For town of 10,000 population in county of 40,000 population located in scenic mountainous section of Northeast Alabama. Office space and equipment available. Hill-Burton hospital-nursing home. Expanding industries in top agricultural area. PW-1-2

For community of 2,000 population, plus large trade area, located in Southeast Alabama. Modern clinic, fully equipped. PW-1-3

Opportunity in port town of 1,000 plus population in population center of 10,000 located in Southeast Alabama. Clinic available. Hospital located less than 20 miles away. Recreational advantages for water sports. Expanding industrial and farming area. Churches and schools. PW-1-4

For town of approximately 1,000 population in Northwest Alabama, near Tennessee Valley waterways. New 15-bed clinic available. Centrally located near metropolitan areas. Extensive industrial developments. PW-1-5

For town of 12,500 population in trade area of 50,000 located in South Alabama. Nearest large city with population of 145,000 is 80 miles away. Two hospitals with 140 beds. Numerous small industries. Several churches and schools. Recreational activities include water sports and golf course. PW-1-6

General Practitioner to join partnership in town of 3,000 population, plus trade area of 20,000 population in northwest Alabama. Modern office building with six examining rooms. Full partnership at beginning of third year. New 30-bed Hill-Burton hospital. Salary open. PW-1/7

(Continued on Page 194)

Physicians Wanted

(Continued from Page 193)

Opportunity in community of 3,000 population with over 8,000 population in trade area, near metropolitan area in northwest Alabama. Clinic and office equipment available. New 400-bed hospital and older hospital, and several nursing homes. PW-1/8

For town of 2,000 population in trade area of 7,000 population located in west Alabama. Physician recently died. Nearest city is 30 miles away. Medical facilities include Hill-Burton hospital and nursing home. Churches, schools, civic clubs, and recreational advantages. PW-1/9

For town of 1,800 population located in southeast Alabama in a population center of 10,000 population. PW-1/10

For town of 7,000 population located in population center of 15,000 population located in northeast Alabama. Office space and equipment available. Hospitals located in adjoining towns within 12 miles. State University located in the town. PW-1/11

For town of 2,500 population located in northeast Alabama. 17-room modern brick clinic fully equipped. Hospital nearby. Excellent schools and recreational advantages, water sports. PW-1/12

For town of 5,000 population, located in northwest Alabama. 55-bed hospital being completely renovated, and an adjoining 69-bed nursing home. PW-1/13

Opportunity in well situated central Alabama county, trade area of 18,000 population, manufacturing, mining, farming region. New office building furnished. 33-bed accredited hospital. Excellent recreational facilities including new country club. PW-1/14

Opportunity for group practice in town of 10,000 population in north Alabama. PW-2

Physician wanted to join 39 year old Medical College of Alabama graduate in a well established general practice in West Central Alabama town. Salary initially followed soon by full partnership. PW-3

Physician wanted to join well established partnership in Northwest Alabama city of 15,000 population. Two accredited hospitals, junior college, schools, churches, recreational activities. No obstetrics or surgery. New office building. PW-7

For city of approximately 15,000 population in north Alabama, with trade area of approximately 45,000 population. Hospital with over 100 beds, and expansion planned for next year. Nursing homes in the area. Industrial growth and agricultural region. Several churches and schools. Golf course, civic and fraternal organizations. PW-8

For town in southwest Alabama, approximately 1,000 population in trade area of approximately 5,000 population, within 60 miles of large city of 35,000. Nearest hospital is located 18 miles away. Arrangements available for office space. Small industries and agriculture. Civic clubs and golf course nearby. Churches and school. PW-13

For town of 1,000 plus population in west-central Alabama in trade area of 20,000. Clinic available. Nearest city of approximately 70,000 population is located a distance of 17 miles. Farming, cattle, timber, and manufacturing plants are principal resources of the area. Churches, schools, and recreational advantages. PW-15

Opportunity for general practitioner to join a five-man group, practicing as a partnership. Each man in the group is either specialized or semi-specialized. The practice is physically located within a 70-bed hospital. Willing to pay qualified person $36,000 for the first year, with possible partnership status in one year. Would consider a physician for locum tenens for three to six months at $2,000 per month. PW-16

For town of 3,600 population in trade area of 5,000-7,000 within 100 miles of two large cities and the Gulf Coast. 50-bed hospital located in the town. Office space available. Agricultural and expanding industrial area. Several churches and two schools. Recreational activities in the town as well as nearby—golf course, hunting and fishing. PW-17

Unusual opportunity for two general practitioners with military obligations satisfied at a modern fifty bed facility located 15 minutes drive from largest metropolitan center in north-central Alabama. Construction of a new two-story office building is scheduled to begin soon. PW-18

Opportunity in city of 5,000 population located in Northeast Alabama in trade area of approximately 10,000 population. Office space available. One physician died recently. Hospital and nursing home in the city. PW-19

* * *

Lack of a test to detect infectious hepatitis virus in the blood of donors makes many of the nation's blood banks vulnerable to a series of costly legal battles, according to a recent survey in *U. S. Medicine*. Absence of a proper test is complicated, said the piece, by the fact that all but 15 states classify blood as a commodity "under their implied warranty laws," which makes it fall "into the same category as hamburger in the supermarket."

* * *

Disease-producing bacteria thrive in automatic washing machines under conditions present in many homes and in coin-operated laundries, it was charged in Congress. Short washing cycles, the absence of effective germ killers in detergents, and the increasing use of cold-water detergents were listed as contributing factors.

"anorectal disorders"



This Rectopath Model
may help you explain certain anorectal disorders to some of your patients. It is yours on request.

See next page for details.

"anorectal disorder"

includes a range of problems. For symptomatic relief in some of these disorders consider a member of the Anusol Family...

One suppository morning and evening and after each bowel movement.

ANUSOL®

soothing, palliative relief of minor pain, itching, burning, and other associated discomforts.

Each ANUSOL suppository contains bismuth subgallate (2.25%), bismuth resorcin compound (1.75%), benzyl benzoate (1.2%), Peruvian balsam (1.8%), zinc oxide (11.0%), and boric acid (5.0%), plus the following inactive ingredients: bismuth subiodide, calcium phosphate, hydrogenated vegetable oil, and coloring in a cacao butter and white wax base.

One suppository morning and evening for 3 to 5 days.

ANUSOL-HC®

prompt reduction of inflammation plus the soothing effects of regular Anusol.

Each ANUSOL-HC suppository contains, in addition to the regular Anusol formula, 10 mg. hydrocortisone acetate.

Precautions: Prolonged use of Anusol-HC might produce systemic corticosteroid effects.

One suppository every 3 to 4 hours, or every 2 hours if symptoms are severe.

ANUGESIC®

when severe pain requires prompt relief, pramoxine HCl plus the soothing Anusol formula.

Each ANUGESIC suppository contains: 61 mg. bismuth subgallate, 47 mg. bismuth resorcin compound, 32.4 mg. benzyl benzoate, 48.6 mg. Peruvian balsam, 300 mg. zinc oxide, 135 mg. boric acid, and 25 mg. pramoxine hydrochloride. Also contains the following inactive ingredients: bismuth subiodide, calcium phosphate, white wax, benzoinated lard, hydrogenated vegetable oil, and certified coloring in a cacao butter base.

Precautions: If idiosyncratic reaction occurs, discontinue medication.
Symptomatic treatment should not be allowed to delay definitive diagnosis and therapy.

Also available: ANUSOL® OINTMENT AND ANUGESIC® OINTMENT



The Rectopath Model is available from your Warner-Chilcott representative or upon request from Warner-Chilcott Labs., Morris Plains, New Jersey 07950.

Warner-Chilcott Laboratories, Morris Plains, N. J.

IN-91-4C

"Shall I order Maalox?"





"Yes. Patients respond well to it, and seem to take it more faithfully."

Works well · Doesn't constipate · Tastes good · Economical

Supplied: Maalox Suspension (12 fl. oz.). *Also available:* Maalox No. 1 Tablets (0.4 Gm.) : no sugar, low sodium content. Maalox No. 2 Tablets (0.8 Gm.) : double strength for double antacid action.

THE NUMBER ONE ANTACID

Maalox®

MAGNESIUM-ALUMINUM HYDROXIDE

WILLIAM H. RORER, INC.
Fort Washington, Pa. 19034

Wheelchair Can Be Disastrous As A Status Symbol

The wheelchair should follow the same principle as prescription drugs: "the minimum effective dosage," New York experts are cautioning, AMA reports.

The wheelchair in some areas is becoming a status symbol, with an array of gadget controls that relieves the patient of all activity except pushing a button. And with the new mechanical engineering feat of harnessing through control, even button pushing may become obsolete!

There are three basic wheelchair models: indoor, outdoor, and amputee type. The indoor chair, with large wheels in front and small ones in the rear, is highly maneuverable in narrow spaces. The outdoor type, with large wheels in the rear, is more easily propelled on all surfaces. A longer wheelbase in the amputee chair compensates for absence of limb weight, making the vehicle more stable.

The proper type depends on the individual patient, AMA suggests. For example, although the outdoor model generally is the easiest to propel, an arthritic whose shoulder and elbow movement is limited would find it difficult to reach backward to the wheels. Thus, an indoor type might be advisable. An emphysema patient, on the other hand, would be more hampered than helped by an indoor model. Self-operation of the chair would cause the body to slump forward, inhibiting movement in the lung area.

After choosing the basic chair, the user can specify seat width and height, wheel size, and attachments. Hydraulic seats can be installed for people unable to stand from normal sitting positions. Exceptionally sturdy chairs can be made for extremely obese invalids. Other accessories may range from signal horns and work trays to motor-drives that operate by a nod of the head and attachments that enable wheelchairs to climb stairs.

Too often, New York University specialists point out, wheelchair buyers go overboard on accessories. The chair becomes a status symbol, a "custom job" with extra gadgets intended to establish superiority. However, excess modifications actually foster dependency and inactivity, instead of encouraging the patient to use the physical abilities he has.

INDEX TO ADVERTISERS

Blue Cross-Blue Shield	125
The Bradley Center	184
Breon Laboratories	119, 120, 121, 122
Bristol Laboratories	153
Burroughs Wellcome	136
Geigy Pharmaceuticals	116, 117, 118
Guest House Motel	181
Highland Hospital	129
Hynson, Westcott & Dunning	109
Lederle Laboratories	111, 131, 161, 162, 171, 175, 179
Eli Lilly & Company	1st Cover, 140
Wm. S. Merrell	113
National Drug Company	2nd Cover, 127, 128
Parke Davis & Company	156
Pitman-Moore Company	176, 177
Riker Laboratories	138, 139, 190, 191, 3rd Cover
Roche Laboratories	132, 133, 134, 135, 4th Cover
Wm. H. Rorer	197
G. D. Searle Company	154, 155
Smith, Kline & French	115, 169
The Stuart Company	159
Wallace Laboratories	164, 165, 166
Warner Chilcott	185, 186, 195, 196
Wyeth Laboratories	172, 173



In Gastritis

anticholinergic
antacid
demulcent
topical anesthetic

it's all here!

Estomul®
Liquid

Each tablespoon (15 cc.) contains:
orphenadrine HCl, 25 mg.;
bismuth aluminate, 50 mg.;
aluminum hydroxide—magnesium carbonate
(as co-precipitate), 918 mg.

Also available as Estomul Tablets:

Each swallow tablet contains: orphenadrine hydrochloride, 25 mg.; bismuth aluminate, 25 mg.; magnesium oxide, 45 mg.; aluminum hydroxide-magnesium carbonate (as co-precipitate), 500 mg.

Indications: Peptic ulcer: duodenal, marginal, gastric, esophageal; gastroesophageal reflux; esophagitis (without stricture); irritable bowel syndrome; hyperacidity and dyspepsia; congenital shortening of esophagus with esophagitis; heartburn; spasm of the cardiac end of esophagus; gastritis; symptomatic hiatus hernia; alcoholic gastritis; functional pylorospasm.

Contraindications: Because of the anticholinergic action of orphenadrine, Estomul should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcers, prostatic hypertrophy or obstruction at the bladder neck, achalasia (megaesophagus), and myasthenia gravis.

Precautions: Doses in excess of six tablets or six tablespoons of liquid daily may produce minor side actions such as dryness of the mouth or blurred vision.

Warning: Use of any drug in pregnancy, lactation or in women of child-bearing age requires that the potential benefit of the drug be weighed against its possible hazards to the mother and child. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Side Effects: Possible side actions include: tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, an elderly patient may experience some degree of mental confusion.

Dosage: For adults: One or two tablespoons of liquid or one or two swallow tablets three times daily; depending on severity.

Availability: On Rx only. 12 oz. bottles of liquid and bottles of 100 swallow tablets.

Riker Laboratories • Northridge, California 91324

The Riker Representatives in your area are: Bob Johnson, Bill Phillips, Bill Crabb

Exchange Office
Francis A. Countway Lib. of
Medicine
10 Shattuck St.
Boston, Massachusetts 02115



When disease is ruled out and psychic tension is implicated

Valium® (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcitec states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE **Roche**
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

JOURNAL

of the Medical Association of the State of ALABAMA

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON
30 SEP 1969

IN THIS ISSUE

Laparoscopy In Gynecology 241

Immunologic Augmentations For Learning And Psychiatry 243

Medicaid Payment For Individual Practitioners - A Definition 255

Write it any way you please

Cordran®

Flurandrenolone



Cream Cordran contains flurandrenolone, 0.05 percent, stearic acid, cetyl alcohol, mineral oil, polyoxyl 40 stearate, ethylparaben, glycerin, and purified water.

Lilly

Additional information available upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

Francis A. Countway Lib. of
Medicine
10 Shattuck St.
Boston, Massachusetts 02115

SEPTEMBER 1969



Dear Doctor, You made me what I am today— a whole lot slimmer!

TEPANIL—the right start in support of t weight-control program *you* recommend. reduces the appetite. Doesn't kill it. Weig loss is significant—gradual—yet there is relatively low incidence of CNS stimu tion. Because TEPANIL works on t appetite, not on the "nerves."

Contraindications: Cancurrently with MAO inhibitars, in pati hypersensitive ta this drug; in emationally unstable pati susceptible ta drug abuse.

Warning: Althaugh generally safer than the amphetami use with great cautian in patients with severe hypertensio severe cardiavascular disease. Da nat use during first trimeste pregnancy unless patential benefits autweigh patential risks.

Adverse Reactions: Rarely severe enaugh ta require discantinuatian af t apy, unpleasant symptams with diethylprapian hydrachlaride have been repo ta accur in relatively law incidence.

As is characteristic af sympathamimetic agents, it may accasianally cause *CNS effects* such insamnia, nervausness, dizziness, anxiety, and jitteriness. In cantrast, CNS depressian has b reparted. In a few epileptics an increase in canvulsive episades has been reparted.

Sympathamimetic *cardiavascular effects* reparted include anes such as tachycardia, precor pain, arrhythmia, palpitatian, and increased blaad pressure. One published repart descr T-wave changes in the ECG af a healthy yaung male after ingestian af diethylprapian hy chlaride; this was an isalated experience, which has nat been reparted by athers.

Allergic phenamena reparted include such canditians as rash, urticaria, ecchymasis, and eryth *Gastraintestinal effects* such as diarrhea, canstipatian, nausea, vamiting, and abdaminal di fart have been reparted.

Specific reparts on the hematapaietic system include twa each af bane marraw depres agranulacytasis, and leukapenia.

A variety af miscellaneaus adverse reactians have been reparted by physicians. These in camplaints such as dry mauth, headache, dyspnea, menstrual upset, hair lass, muscle decreased libida, dysuria, and palyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swall whale, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, ane haur b meals. If desired, an additianal tablet may be given in midevening ta avercame night hu Use in children under 12 years af age is nat recammended.

Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride)

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144 T-918A U.S. PATENT NO. 3,001,910

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)



BROMSULPHALEIN® IN A STERILE, DISPOSABLE, ECONOMICAL UNIT

The Bromsulphalein test is a convenient, sensitive, reliable test of liver function.

The precalibrated syringe contained in the BSP Disposable Unit makes weight calculations unnecessary, providing proper dosage regardless of patient-weight. Each unit contains complete directions for use, precautions and contraindications.

The all-inclusive BSP Disposable Unit provides economic unit dispensing.

Complete literature available on request.

HYNSON, WESTCOTT & DUNNING, INC.

Baltimore, Maryland 21201

(BSP04)

THE JOURNAL

of the

Medical Association of the State of Alabama

Volume 39 • September, 1969 • No. 3

Office of Publication
19 So. Jackson St. Montgomery, Ala. 36104
Subscription Price $5.00 Per Year
$1.00 Per Copy

Second Class Postage Paid at Montgomery, Alabama. Published monthly in Montgomery at 19 South Jackson Street.

Editor-in-Chief
William L. Smith, M. D. Montgomery

Managing Editor
L. P. Patterson Montgomery

Assistant Managing Editor
Mary Nell Williford Montgomery

Associate Editors
J. P. Collier, M. D. Tuscaloosa
John M. Chenault, M. D. Decatur
M. Vaun Adams, M. D. Mobile

Officers of the Association

President
C. Kermit Pitt, M. D. Decatur

President-Elect
S. Buford Word, M. D. Birmingham

Vice-Presidents
F. M. Phillippi, Jr., M. D. Brewton
J. E. Cameron, M. D. Alexander City
O. Emfinger, M. D. Union Springs
Wood S. Herren, M. D. Birmingham

Secretary-Treasurer
William L. Smith, M. D. Montgomery

Executive Director
L. P. Patterson Montgomery

The State Board of Censors
John M. Chenault, M. D., Chmn. Decatur
J. P. Collier, M. D. Tuscaloosa
Hugh E. Gray, M. D. Anniston
Paul W. Burleson, M. D. Birmingham
L. L. Hill, M. D. Montgomery
M. Vaun Adams, M. D. Mobile
J. D. Bush, M. D. Gadsden
E. L. Strandell, M. D. Brewton
John W. Davis, Jr., M. D. Montgomery
J. Garber Galbraith, M. D. Birmingham

State Health Officer
Ira L. Myers, M. D. Montgomery

Delegates and Alternates to the American Medical Association

(Terms expiring December 31 of year shown.)

1970
Delegate—E. Bryce Robinson, Jr., M. D., Fairfield
Alternate—W. E. White Anniston

1971
Delegate—M. Vaun Adams, M. D. Mobile
Alternate—E. L. McCafferty, Jr., M. D. Mobile
Delegate—P. W. Burleson, M. D. Birmingham
Alternate—Robert Parker, M. D. Montgomery

CONTENTS

President's Page 202

Woman's Auxiliary 204

Editorial Comment 208

. . . Or Be Very Certain The Doctors Will Hang Separately 208

We've Got A Real Good Thing, But Can We Keep It? 208

The Adolescent And His Sophomoric (or "Sophisticated") Rebellion 211

Lead Or Be Led—Be Led and Be Damned 214

Guest Editorials

Where Will It End? 215

The Cabin, The Womb, Health Care—All Shelter of a Kind 216

When A Onetime MASA President and A Governor Developed TB 218

Origins of Common Bacteriological Terms and Names 227

Fathers and Sons In Medicine 238

The Warrens of Mobile 238

The Hubbards of Montgomery 239

Scientific Section 241

Laparoscopy In Gynecology, D. Erskine Carmichael, M. D., Birmingham 241

Immunologic Augmentations For Learning And Psychiatry, Wallace Marshall, M. D., Montgomery 243

Association Forum 255

Medicaid Payment For Individual Practitioners—A Definition 255

Percentile Payment Formulas as Used in Medicare and Medicaid 260

Book Review 270

Around the State 278

New Physicians Licensed to Practice in Alabama 278

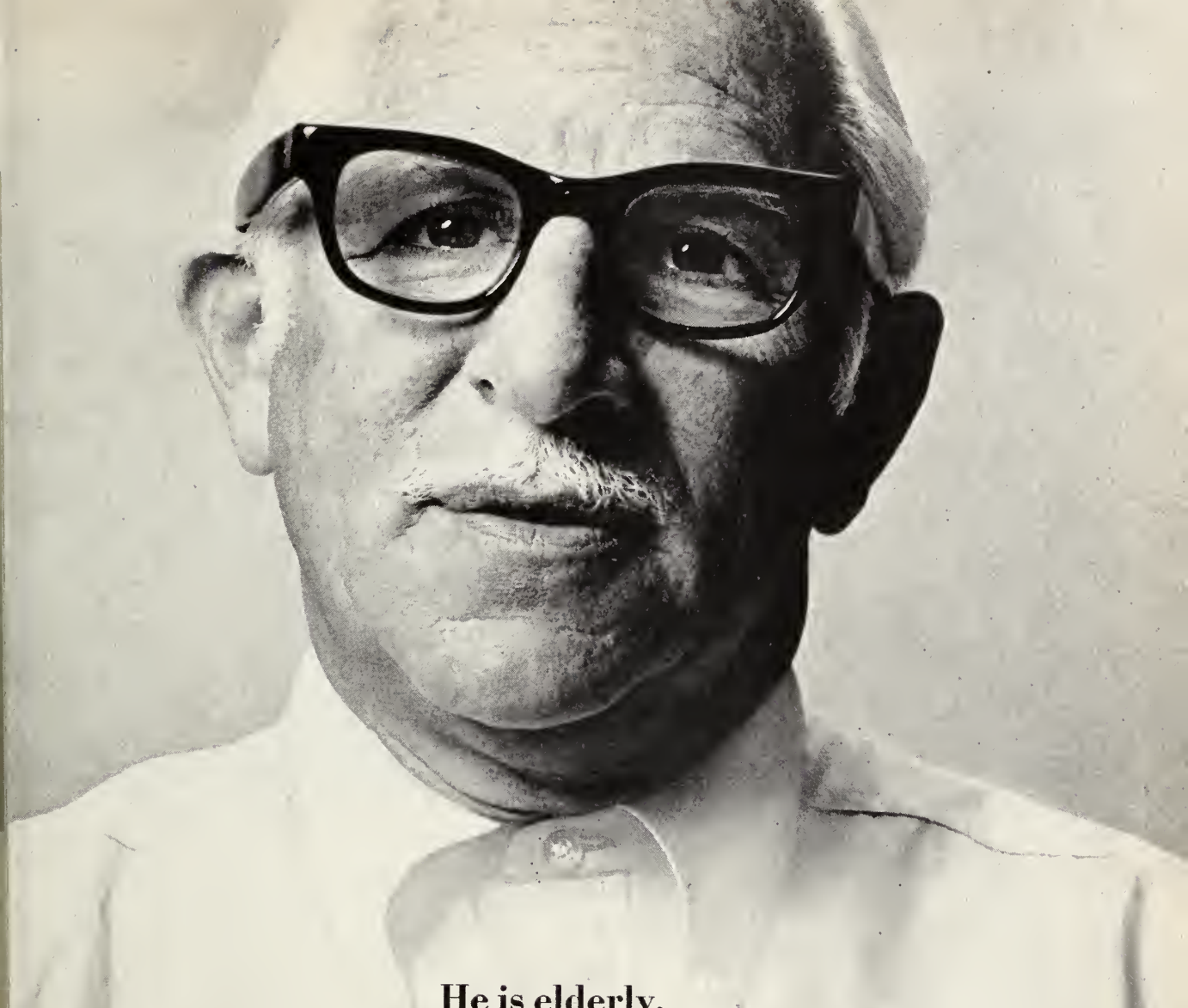
Vital Statistics 294

With Two Interns Plus Medical Students, Montgomery Moves Up To Birmingham and Mobile 299

Mrs. John Chenault, Dr. Pitt Honored by "Home Folks" 303

Physician Placement Service in Alabama 304

Meet ALAPAC's Director From The 5th Congressional District 306



He is elderly, he is on corticosteroids, when he needs an antibiotic he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

urd susceptible patients against intestinal monilial over- v during broad-spectrum therapy—the protection of ain is combined with demethylchlortetracycline in DSTATIN.

our susceptible candidates, prescribe DECLOSTATIN oad-spectrum therapy that prevents monilial wth.

dication: History of hypersensitivity to demethylchlortetracy- ystatin.

: In renal impairment, usual doses may lead to excessive accumu- d liver toxicity. Under such conditions, lower than usual doses ated, and, if therapy is prolonged, serum level determinations dvisable. A photodynamic reaction to natural or artificial sun- been observed. Small amounts of drug and short exposure may an exaggerated sunburn reaction which may range from ery- severe skin manifestations. In a smaller proportion, photo- reactions have been reported. Patients should avoid direct to sunlight and discontinue drug at the first evidence of skin rt. Necessary subsequent courses of treatment with tetracy- ould be carefully observed.

ns: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES, A Division of American Cyanamid Company
Pearl River, New York

President's Page



C. Kermit Pitt

Allied Health Man-Power

From inside and outside the medical profession the major thrust today is toward closing the gap between "our enormous technological know-how" and its delivery and applicatien to those who need and demand it. The public and the federal government are taking an increasing interest in medicine and leveling much criticism at the American health care system, or "non-system" as it is being labeled by many.

Dr. David E. Rogers, Vice President for Medicine for Johns Hopkins University, Dean of the Medical School and Director of the University's hospital, recently wrote "in this country we have neither planned nor developed the health care system that is able to make fully effective use of our enormous technological know-how.

"Teachers of medicine have educated medical students in basic biological knowledge and have trained them to handle diseases skillfully. In so doing, we have ignored the whole problem of how medicine applies to society and have not made it clear that we have responsibilities in this broad general area.

"Although we have inculcated feelings of great responsibility for the individual patient, we have failed to indicate that the social aspects of medical care are very important." Dean Robert H. Ebert, Howard Medical School, recently said, "Students, house officers and residents must be made as aware of the social problems of medicine as of the biological ones." Secretary of Health Education and Welfare, Robert Finch, recently stated his conviction that the American people will not much longer tolerate the inequity between the state of the healing arts and the delivery system. A United States Chamber of Commerce executive recently made the same suggestion.

Organized medicine is not unaware of these problems. During the annual meeting of the American Medical Association in New York, July, 1969, much emphasis was placed on and study given to the challenge of increased demand for, delivery of, and payment for comprehensive medical care. Dr. Robert C. Long, Trustee of the American Medical Association recently named three important areas of immediate concern for that organization: "Health man-power, financing of health care costs, health care for the poor."

Research activity must continue and the so-called gap be closed by increasing effective delivery of medical care rather than by decelerating the acquisition of knowledge, but research must include the consideration of new methods and technology for delivery,

including the production of man-power (physicians, nurses and other para-medical personnel), as well as the development of scientific ways for mass delivery, including the use of computers and other machines.

The remainder of this discussion will be devoted to a review of some of the efforts to provide additional man-power now in progress. It is not necessarily an endorsement but is given with the conviction that members of the medical profession must be continually aware of all activities pertaining to health care and must involve themselves in those which they approve.

Acceleration in the demand for comprehensive medical care exceeding the capacity of physicians to fulfill it, despite efforts to increase their number as rapidly as possible, is occurring. This acceleration has resulted from rapid population explosions, education, economic affluence and, particularly, various state and federally sponsored health plans including Medicare, Medicaid, Appalachia, Regional Medical Program, Head Start, O. E. O., etc. When this nation voted for medical subsidies it, in effect, declared that first-class medical care is a basic human right, regardless of income and, as a consequence, we have demands for physician's services from millions of people who heretofore saw doctors only in cases of emergencies or in grave illnesses, if at all.

Although medical schools anticipate doubling their student capacity in the next 10 years, this will fail to meet the medical man-power needs. Presently the American people are served by approximately 305,000 physicians. By 1975 estimates indicate a need for 400,000 to provide care for expanded population and accelerated utilization. The output of our medical schools at present planning levels plus the addition of continued immigration of foreign physicians will give us no more than 360,000 by that time.

In my own specialty, Pediatrics, there is concern because it is estimated that by 1980 there will be approximately 76 million chil-

(Continued on Page 265)



You can give a better ear exam EASIER with the new Hotchkiss™ Otoscope

A radical advance in otoscope design, the Hotchkiss employs the principles of modern optics to give you a brighter, clearer, more informative view of the ear canal and tympanic membrane. It weighs just five ounces (including batteries) and fits into your shirt or jacket pocket. You can carry it anywhere; use it repeatedly without fatigue. And the Hotchkiss is built to stand up to far rougher treatment than you're likely to give it.

See for yourself. Clip and mail the coupon, and our Representative will call for an appointment to show you the new Hotchkiss Otoscope in your office.

SK&F **Smith Kline & French Laboratories**

Smith Kline & French Laboratories E-30 A
1500 Spring Garden Street
Philadelphia, Pa. 19101

I would like your Representative to call for an appointment to show me the Hotchkiss Otoscope.

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

☐ Send descriptive literature

The Woman's Auxiliary

President, Mrs. Ben H. Johnson, Jr.
President-Elect, Mrs. Howard C. Johnson
Northeast District Vice President, Mrs. James D. Holliman, Jr.
Northwest District Vice President, Mrs. Gene Qualls
Southeast District Vice President, Mrs. George Andrews
Southwest District Vice President, Mrs. Andrew D. Henderson
WAMASA Editor, Mrs. William L. Smith

AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the Medical Association of the State of Alabama. I will support its activities, protect its reputation and ever sustain its high ideals."

The AMA Convention was such a big event for the Alabama Delegation that I must comment on the doings. As we stood in the receiving line at the magnificant reception honoring Dr. Dorman and Mrs. Chenault the gracious and beautiful people from Alabama appearing from time to time among the many hundreds were as refreshing as magnolias and gardenias as they paid tribute to our Belle and Dr. John Chenault. Belle is an outstanding leader and beloved by all. And you would have been proud of your president and his presentation of the elegant gift to her, the comments were audible and numerous concerning "that cute and clever Dr. Pitt from Alabama."

The many other events were enjoyable and of such significance that it was one of the most memorable conventions for me, indeed, I saw it to the close with reluctance. New York itself was so very exciting and as we went about the night spots there was a generous sprinkling of doctors and their lovely wives everywhere.

August 14 was a big date for the Auxiliary, the Executive Committee consisting of the elected officers, chairmen of the standing committees, and County Auxiliary presidents, met at the Ramada Inn in Birmingham. The agenda was filled with many items, with membership given priority. We have come to the crossroads in our organization where growth is a must and how to encourage new members was number ONE in the discussions. Again, we come right back to our main source of members, the doctors, themselves.

I have made a point of discussing Auxiliary and membership with the many doctors with whom I have contact, and invariably the answer is that we do not have projects that sufficiently interest their wives. The County Auxiliaries have many projects, one such project was featured at the National Convention. Tuscaloosa County had an outstanding display on "Poison Control in the Home." Our aim as an Auxiliary is to study the community and decide what needs to be done for better health, then do it. This can be done in a number of ways. We can work on it as an Auxiliary or join with other organizations and help them. I challenge



Mrs. Ben H. Johnson

(Continued on Page 207)

vacation in a vial: the spasm reactors in your practice deserve



"the Donnatal® Effect"

	each tablet, capsule or 5 cc. of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	(1/6 gr.) 16.2 mg.	(1/2 gr.) 32.4 mg.	(3/4 gr.) 48.6 mg.
(Warning: may be habit forming)			

Brief Summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

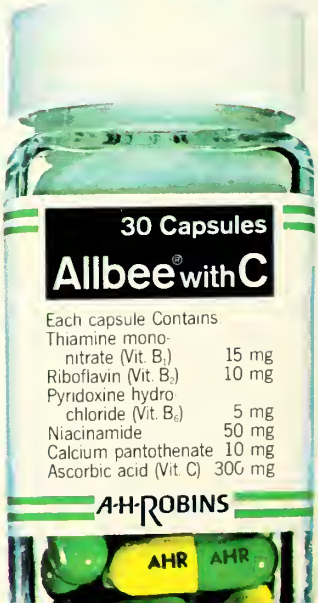
A·H·ROBINS

Two ways to provide your patients with a month's therapeutic supply of Vitamin C:



290 tangerines or 30 Allbee® with C.

Your patient would have to peel and eat 290 tangerines a month, almost 10 every day, to get as much Vitamin C as is contained in just one bottle of 30 Allbee with C capsules (taken one capsule daily). In addition, each capsule provides full therapeutic amounts of the B-complex vitamins. For example, as much niacin as 2 pounds of sirloin steak. This handy bottle of 30 Allbee with C capsules gives your patient a month's supply at a very reasonable cost. Also the economy size of 100. Available at pharmacies on your prescription or recommendation.



A.H. Robins Company, Richmond, Va. 23220

THE WOMAN'S AUXILIARY

(Continued from Page 204)

anyone to say that Auxiliary work is not worthwhile. Our work is our reason for being and it is up to the individual county groups to decide what is best for their county.

In addition, I challenge anyone to say that our contribution of over $14,000 to AMA-ERF is not worthwhile. Every doctor's wife ought to be proud to be a part of this joint effort that puts $428,875.77 into medical education. This is the total contributed in 1968-69 from the fifty states. And while we are on this worthy subject, don't forget that every memorial helps our total. Again I urge you to make out your check to AMA-ERF Auxiliary Fund and mail it to Mrs. Richard A. Dillard. If you are in doubt how to go about sending a memorial, put the check in the mail to her and she will do the rest. She sends out dozens of these Memorial cards for busy doctors.

We were very pleased to hear the praises that came our way concerning the amount we contribute, we rank eighth in the fifty states and we are mighty proud of all of you and thank you for your continued support. If the over $6,000.00 that went in last year from doctors in Alabama who sent it direct and not through our Auxiliary, had gone in through the Auxiliary Fund, we would have won a National Award which would have been very nice. We want to make it big this year, so won't you continue to give and to give more generously and through the AUXILIARY FUND?

Whether we are a success or not in our Auxiliaries lies within the individual members for as Shakespeare said long ago, "The fault, dear Brutus, lies not in our stars—but in ourselves that we are underlings."

Ruth R. Johnson

(Mrs. Ben H. Johnson, Jr.)
President, WAMASA

Wonderland or Wasteland?

The word "addiction" is being dropped from the vocabulary of drug-abuse experts. "Dependence," which can be either physical or psychological, tends to replace it.

Drug abuse might be called a "chemical experience," suggests an article in *Emphasis,* the Smith Kline and French magazine, captioned "Drug Abuse—Wonderland or Wasteland?" The experience is defined as "a way of altering the normal processes of consciousness so that, for a short while at least, life is felt to be different."

The piece reviews the whole spectrum of the problem, in light of the modern adaptation of Alice and the White Rabbit, and, quoting the punchline of the LSD song, "Go ask Alice when she's ten feet tall," it concludes:

"If they're lucky, maybe Alice will tell them that a trip to Wonderland may only be one way."

Not just a motel
it's a Guest House

. . . with 171 handsome rooms designed for your comfort and convenience. A center-of-everything location including Birmingham's University of Alabama Medical Center . . . making The Guest House a favorite of Doctor's wives and in-town outpatients. Superb dining, dancing and nightly entertainment. Come stay with us often.

THE RESTAURANT
THE PLAYROOM • CYPRESS ROOM
CONVENTION FACILITIES



The Guest House
MOTOR INN

PHONE 324-8653
18TH ST. &
10TH AVE., SOUTH
BIRMINGHAM, ALABAMA

"Where the Action Is!"



. . . Or Be Very Certain The Doctors Will Hang Separately

Andrew Tully, the syndicated columnist, who referred to the AMA recently as the American More-or-Less Medical Association, is the perfect illustration of the political "moderate" in his approach to medicine.

Contemptuously, he refers to Dr. Richard Kunnes, "a long-haired senior resident at New York City's Albert Einstein Hospital," and who called the AMA "the American Murder Association," as one who "burned his AMA card and generally behaved like a sophomore at Drop Dead U who hates his kiddie car."

This, protests Tully, "is not the way to build a viable opposition to the AMA's greedy and horse-and-buggy thinking." The tragedy of Kunnes and his wet-eared pals, he continues, "is that they made friends for the AMA with their lunatic howls and their march from the hall with clenched fists upraised in the old Commie-Black Panther salute. My gracious, even I am forced to defend the AMA against this adolescent onslaught."

Wherein Tully, who earns his living writing, proves only that he is more articulate than Kunnes. His resentment of Kunnes, in a nutshell, is that the extravagance of Kunnes has embarrassed and handicapped the enemies of medicine.

Tully and Kunnes prove one thing:

Organized medicine had better hang together. Or be very certain that its individual members and groups will hang separately!

We've Got A Real Good Thing, But Can We Keep It?

". . . We've got a real good thing!"

So says the singing commercial of one brand of cigaret. The swing of the song is intended to needle its way into the subconscious so that when the smoker orders a pack, the next time, he—or more usually *she*—will ask for that brand by name.

Sex and song are the most powerful weapons in the arsenal of salesmanship—whether what you have to sell is a candy bar or a luxury car, a Hollywood production or an order of groceries, a bucket of paint, a modern artist's canvas, a political principle or a religious cult.

". . . We've got a real good thing." It's a good and effective singing commercial for today. But the cigaret manufacturer will have to dream up something new and different for tomorrow, or yield popularity to a rival product.

Do you remember and wonder what has become of some of the commercials of yesterday? "Not a Cough in a Carload." "Reach for a Lucky instead of a Sweet." Or that long-lived trademark composed for one cigaret manufacturer by the late Champ Pickens of Alabama: "They Satisfy."

Some have survived, but with changed commercials, retouched images. And there's a lesson for Medicine in the fact.

In AMA and its collaborating associations, we have a real good thing. But can we keep it?



Painful night leg cramps...

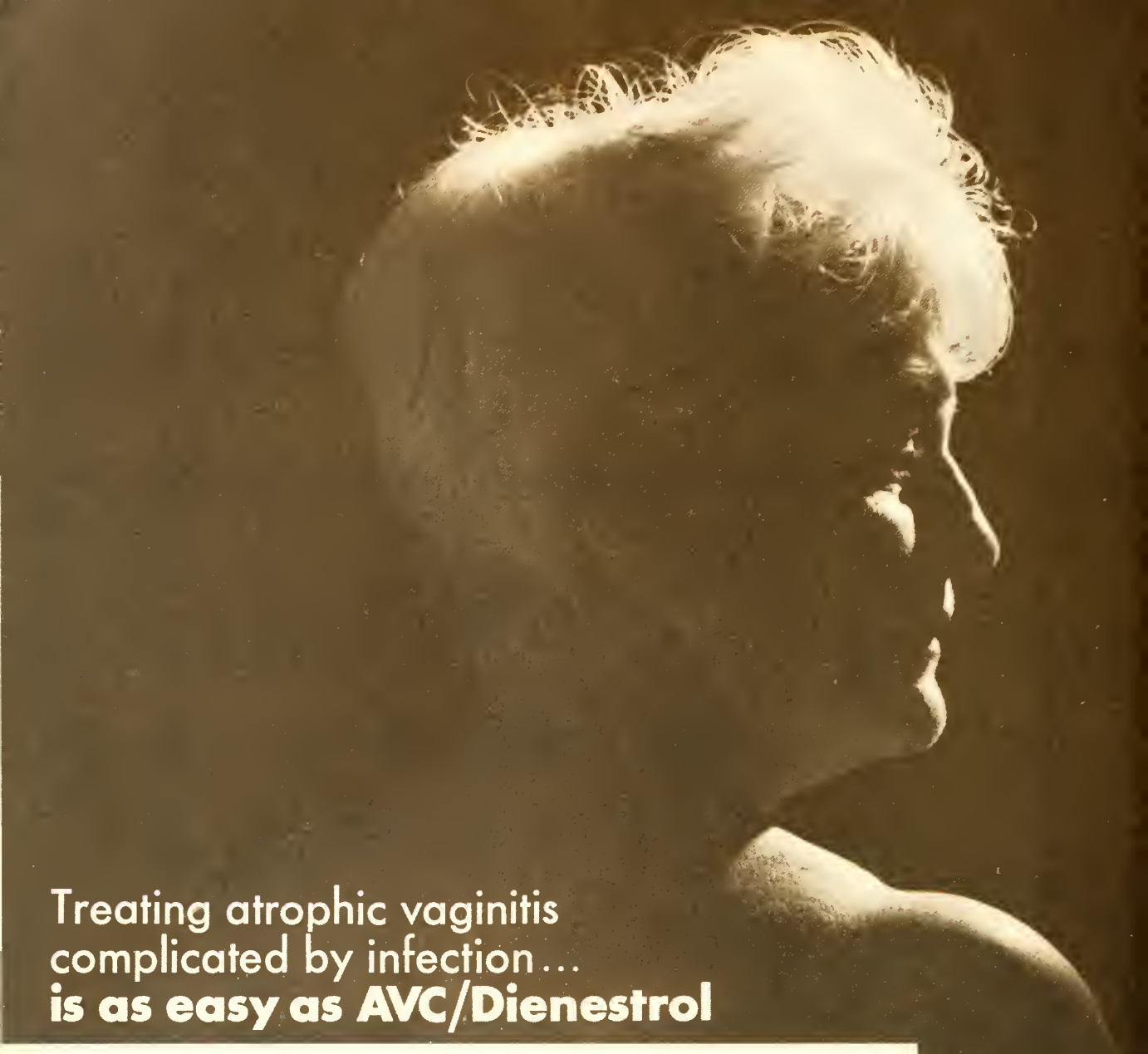
unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Informotion—Composition: Each white, beveled, compressed toblet contoins: Quinine sulfote, 260 mg., Aminophylline, 195 mg. **Indicotions:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with orthritis, diabetes, varicose veins, thrombophlebitis, orterlosclerosis and static foot deformities. **Controindicotions:** QUINAMM is controlndicated in pregnancy because of its quinine content. **Precautions/Adverse Reoctions:** Aminophylline moy produce intestinal cramps in some instonces, and quinine may produce symptoms of cinchonism, such os tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deofness, skin rosh, or visual disturbances occur. **Dosoge:** One tablet upan retiring. Where necessary, dosoge moy be increased to one toblet fallowing the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™ Specific therapy for night leg cramps
(quinine sulfate 260 mg., aminophylline 195 mg.)



Treating atrophic vaginitis complicated by infection... **is as easy as AVC/Dienestrol**

Dienestrol helps restore estrogen-deficient vaginal mucosa. It is the *particular* ingredient in AVC/Dienestrol that improves cell maturation counts[1,2] — helps stimulate the restoration of normal vaginal epithelium to resist infection.

Two recent studies reconfirm AVC/Dienestrol efficacy.[1,2] AVC/Dienestrol is proven effective against monilial, trichomonal, nonspecific bacterial vaginitis, and mixed infections.[1,2] AVC/Dienestrol combats infection, helps restore tissue resistance to reinfection.

So even in complex cases, the treatment can remain the same. Comprehensive. Effective. Easy as AVC/D.

Contraindications: Known sensitivity to sulfanamides; diagnosis or familial history of carcinoma of the genital tract or breasts; precarcinomatous lesions of the vagina or vulva; palpable uterine fibromyoma; mammary fibroadenoma; depressed liver function.

Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfanamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfanamide toxicity or sensitivity are reasons to discontinue treatment. The use of AVC/Dienestrol does not preclude the necessity for careful diagnostic measures to eliminate the possibility of neoplasia of the vulva or vagina. Manifestations of excessive estrogenic stimulation through dienestrol absorption may occur. These include uterine bleeding, breast tenderness, exacerbation of menstrual irregularity and provocation of serious bleeding in women sterilized because of endometriosis. Endometrial withdrawal bleeding may occur if use is suddenly discontinued.

Dosage: One applicatorful or one suppository intravaginally once or twice daily.

Supplied: 'AVC/Dienestrol Cream'—Four ounce tube *with* applicator. 'AVC' and 'AVC/Dienestrol Suppositories'—Box of 12 *with* applicator.

References: (1) Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. (2) Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

AVC/Dienestrol

Cream (dienestral .01%, sulfanilamide 15.0%, aminacrine hydrachloride 0.2%, allantain 2.0%)
Suppositories (dienestral 0.70 mg., sulfanilamide 1.05 Gm., aminacrine hydrochloride 0.014 Gm., allantain 0.14 Gm.)

TRADEMARK. A V C AV-920A 7/69

The Adolescent And His Sophomoric (or "Sophisticated") Rebellion

Adolescence is a time of change and experimentation, a time of challenge to authority, a time of loss of communication, and of a blind pursuit of "freedom."

In the demand for change, the adolescent loses respect for church and parent alike, openly questioning the adult double standard and rote beliefs, with emphasis on the moral issues involved.

In experimentation, the adolescent has ranged the field by generations, from Joe College to Ben Beatnik, from cigarets and redlight-district sex to the use of LSD and marijuana.

Rebellion against authority is a trademark of the age, whether against police, parents or school officials; and whether or not the student has an alternative suggestion.

The communications gap is self evident, between adolescents and grownups even more consistently than between races or religions, nations and social levels and factions. The school communications gap between administration, teachers and students is being underscored in every corner of the world.

And freedom! The adolescent, whether individually or by distinctive group lines, demands it without knowing or admitting that responsibility is the only key to fit the lock.

Dr. Gilbert Houston of Warwick, R. I., read a paper last November before a Symposium on Medical and Psychological Problems of College Students, at Rhode Island Hospital, from which much of the foregoing was paraphrased, and went on to say that:

"Sophistication is part of their (the adolescents') makeup and although it is used very often as a substitute for knowledge, the former is easily recognized. Their lack of anatomical knowledge of themselves and their counterparts is often glaring."

Then he went on to say:

"Social problems of students have long been present, but there is no question regarding the increases in venereal disease, homosexuality, drug addiction, alcoholism, and suicide in the adolescent.

"Suicide is about 3 per 1000 in the college age group. It is the second ranking cause of death. One should take suicidal attempts seriously, since the rate of success increases with each attempt. Young women usually take overdoses of sedatives, whereas young men choose more violent means. Loneliness, oppression by parents, erotic crushes, suicidal fantasies, love, hate, and yearning for freedom are often blamed as the causes. Suicide is associated with mental illness in only 10 per cent of the cases; the remainder are usually of a situational nature. The intelligence of the students is often in the superior range, and there is poor interaction between the environment and rich fantasy life.

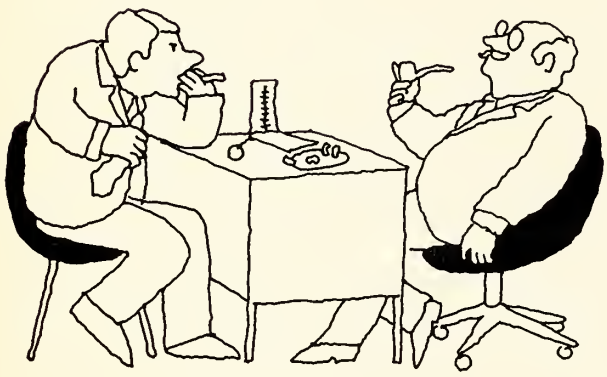
"Agitation, sudden change in behavior and personality, anxiety, depression, anorexia, and insomnia are all danger signals. A listening ear to all adolescents in time of such need, if only for a few minutes, may be life-saving.

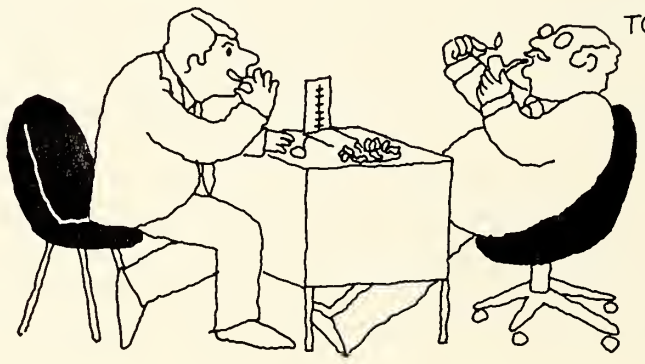
"One's main objective in this age group is to help individuals build values by which to live and standards by which to make important decisions that will affect their future years."

To Help Find Lung Cancers Fast

Development of a sputum test similar to the perfected "pap" test for cervical cancer may help solve the problem of discovering lung cancer before it is too late. Methods and instruments for collecting, processing, and examining sputum specimens will be developed and evaluated by investigators at Johns Hopkins working under a National Institutes of Health contract administered by the National Cancer Institute. The program is being directed by Dr. John K. Frost, Associate Professor of Pathology at the Johns Hopkins University School of Medicine and Director of the Cytopathology Laboratory.

The Apprehensive Hypertensive



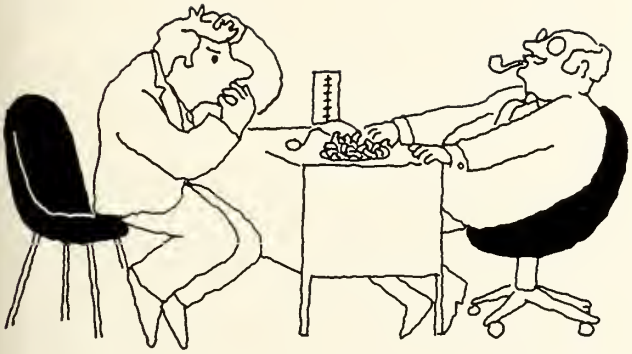


Regroton® to lower blood pressure

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Regroton®: chlorthalidone 50 mg., reserpine U.S.P. 0.25 mg. *Indications:* Hypertension. *Contraindications:* History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. *Warning:* With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. *Precautions:* Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy the drug should be discontinued and potassium supplements given provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving

WE'VE GOT TO GET PLENTY OF REST AND TRY TO AVOID SITUATIONS THAT MAKE US ANXIOUS OR TENSE. AND WE'LL TAKE MEDICINE TO LOWER OUR BLOOD PRESSURE AND CALM US DOWN.



WE'VE GOT PROBLEMS.



and allay anxiety in hypertension

corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. *Adverse Reactions:* The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. *Average Dosage:* One tablet daily with breakfast. *Availability:* Pink, single-scored tablets in bottles of 100 and 1000. (B)46-600-C

For details, please see complete prescribing information.

Regroton®

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

RE-6742

Lead Or Be Led—Be Led And Be Damned

Medicine has come a long way since the turn of the century.

Life expectancy then was 46 years. The principal killer diseases were diphtheria, pneumonia, typhoid and tuberculosis. There was essentially no sphygmomanometer, no X-ray diagnosis, no blood chemical tests, no specific treatment of disease, no specialization of physicians.

Elective operations, as AMA President Dwight L. Wilbur pointed out in a recent article in the *Massachusetts Physician*, were "rare because asepsis, intravenous fluid therapy, blood transfusions and good anesthetics were yet to come. There were nurses, but few other allied health personnel."

Medicine has come a long way since then. And what role do you think the three divisions of our government—the administrative, the legislative, and the judicial—have played in that progress? The answer is: None, whatsoever.

But while Medicine has continued to look through its microscope and listen through its stethoscope, its finger on the pulse of the individual patient, Practical Politics has kept an ear to the ground, an eye on the way ahead, and a finger on the public pulse.

With the close of World War II, things began to happen to Medicine that with mounting crescendo provided a rude awakening, too late for some quarters of the world, notably England with its program of socialized practice. Politicians in the United States saw the possibilities for making political capital of the British program, and it was almost too late when organized Medicine awoke to the threat.

That it is now thoroughly awake is best illustrated by a heading in the Congressional Quarterly:

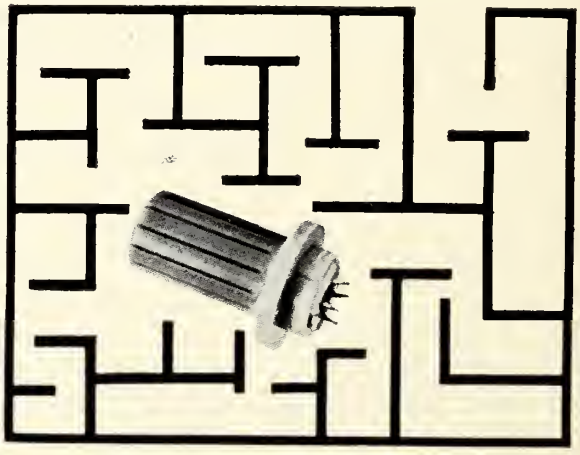
AMA IS RICH SOURCE OF CAMPAIGN FUNDS.

Facing up to the fact that in the United States *money talks*, the doctors of the nation may be very happy over the ability of medicine to speak with authority on the national front.

And Alabama doctors particularly may be interested to know that AMPAC (the American Medical Political Action Committee, if you've forgotten) sent back to Alabama in 1968 campaigns over $3,000 more than it received from ALAPAC memberships in that same year.

Even in this day of getting something for nothing from whom our World War II allies contemptuously labeled "Uncle Sugar," Alabama non-members of ALAPAC will find no cause there for self-congratulations.

The doctors of other states helped foot our political bills.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST

(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES

A Division of American Cyanamid Company, Pearl River, New York

473-9

Guest Editorials

Where Will It End?

In Michigan, an appellate tribunal reversed a lower court which prohibited the plaintiff from using the defendant doctor as an expert witness *against* himself. The court said that, "a civil defendant has no protection against subjecting himself to liability. If his testimony will provide facts which will aid the court in arriving at a just decision, he has the duty to testify. Any loss to the sporting aspect of the adversary proceedings would be outweighed by the benefit to the judicial system." The courts therefore make quite a distinction between a murderer or rapist and a physician on trial for malpractice. The criminal is prohibited from testifying against himself.

The time-worn and flimsy excuse for liberalizing rules of evidence and new methods for proving malpractice is the "conspiracy of silence." This seems to mean that if a physician reviews the evidence and doesn't find a departure from the standard of care and cannot therefore testify that malpractice existed, he is a "conspirator" against the patient who is praying for an award. It simply is not true that every law suit against a doctor resulted from malpractice. If a physician has done nothing wrong, why should the plaintiff's attorneys become so irate because other physicians refuse to testify that he has?

There has been no dearth of suits against doctors in recent years, and every case has produced physicians who testified in behalf of the plaintiff. Where is the conspiracy of silence?

The "locality rule" has virtually been eliminated by the courts. In the past, the plaintiff had to establish that the defendant physician departed from the standard of practice in the community in which the doctor practiced. The theory now imposed is that because of modern transportation, communication, text books, T. V. medical education, postgraduate courses, medical literature and meetings, even the "similar community" ruling is a thing of the past. A small community without a resident radiologist, a pathologist who visits twice a week, no intensive care unit, no anesthesiologist, (perhaps a colleague who does the best he can in anesthesia in emergencies), no coronary care unit, no respiratory care unit, no interns or residents, no facilities for blood gases, no cardiologist, internist, pediatrician, allergist and so on, certainly does not give the small town doctor the same resources or ability to handle difficult and serious cases. It isn't the "wives" who are driving the doctors out of the small towns. It is the courts who hold the county practitioner now to the same standard of excellence as the physicians in the large centers with unlimited consultive and other facilities.

This and the doctrine of res ipsa loquitur, uninformed consent, recovery for mental suffering, the statute of limitations running from the time of discovery and some more permissive rulings, are in the opinion of many, as ridiculous as the recent ruling that unions have a vested interest in limiting production and it is therefore proper to fine union members for exceeding their quota.

Many professional liability carriers have withdrawn from the malpractice field. Some insurance companies will not write policies covering physicians who do any operative procedures. As a recent medical magazine article pointed out, a doctor makes thousands of life and death decisions in the course of his professional lifetime, yet if he makes one wrong decision, he may lose all he has worked a lifetime to acquire plus his professional

Reprinted from the July Issue of *Arizona Medicine*.

reputation, and be unable to obtain liability insurance thereafter.

The physician shortage becomes more and more acute. Even so there is talk of re-licensing examinations at three year intervals and the training of sub-doctors. Who will accept the legal responsibility for these physician-aides? Certainly the number of M. D.s will be reduced by re-licensing, and early retirement because of the inability to obtain malpractice insurance or excessive premiums. Many excellent surgical assistants are not helping on cases they do not originate because this puts them in the category four classification of a surgical specialist with current premiums of $1280.00 per year, and no end to the premium rise in sight.

I have heard, but have not confirmed the statement that plastic surgeons in Florida cannot obtain malpractice insurance at any price. Some physicians who have had claims against them are rated up to above $4000.00 a year in premiums, and you are familiar with the mass cancellations of malpractice policies in Utah and Alaska. Midwest Mutual cancelled all of their policy holders as of February 23rd. Aetna is no longer writing surgical specialists, and there is no doubt whatsoever about the courts practicing medicine. The high cost of medical care is greatly contributed to by the need for the physician to protect himself. It is questionable whether this makes for a higher standard of practice.

In Canada and Britain it is both unethical and illegal for a lawyer to accept a case on a contingency basis, and they have very few "nuisance" suits. Forty per cent of a recent award for $1,500,000.00 is a pretty hefty fee for a few weeks work. What do you get for saving a life? What became of making the plaintiff pay court costs if he loses a suit? Recently a malpractice action in Flagstaff took five weeks in trial. What did this cost the taxpayers? How much important business was delayed as a result of the interminable presentation of the plaintiff's lawyer in a case that in many opinions should never have been permitted to come to court?

Will the day come when a doctor will be forced to say, "I'd like to help you, but I just can't take the risk!"

Where will it all end?

—The Bulletin.

The Cabin, The Womb, Health Care—All Shelter of a Kind

by

Walter P. Batson, M. D.

Editor, The JCMS Bulletin

Many small covered benches dot country roads in some sections of the country. These covered niches are built to shelter the school children who are waiting for their buses. Cabins and lean-tos are built in the woods, the mountains and along the snow covered trails to provide shelter for the hiker, the hunter or the skier. Thus we see all around shelters to serve a specific purpose for a particular type of being. Barns are built for cattle, stables for horses, houses and pens for dogs and pigs. Each is built to provide the needed care in each case and to protect each species from the outside world.

For a period of nine months the human fetus is sheltered in its mother's womb, safe, warm and nourished by its host. The first loud cry of the newborn often brings forth the comment that the new one did not want to leave its warm and protected environment and enter the cold cruel outside world. However, to continue to remain inside would inevitably result in its demise.

A young child leads a very sheltered life. Its parents supply cover, clothes and food so

that all the child has to do is to grow up strong knowing that it is wanted and loved. However, like anything else, the child must eventually leave the shelter of its home and enter the competitive outside world. Failing to do so would result in a child tied to its mother's apron strings, unprepared to cope with adulthood and the many responsibilities of life.

Often people take shelter in religion. Finding the trials of life too severe they turn to the church, withdrawing from life itself and become religious fanatics. Certainly religion can be a comfort in all situations and one would be very foolish not to turn to the church and religion for comfort and support. Belief in God can give one strength to overcome most if not all of life's problems, but to use the church and religion as a shelter against the world defeats its purpose on earth and leaves the sheltered one weak and withdrawn.

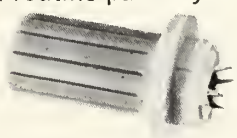
Today a different type of shelter is being advocated by many. These people would like to set up a society which would be sheltered from all harm. Complete health care would be provided by a benevolent government. A guaranteed annual wage would be paid to all regardless of the work done. Food would be supplied to all in need regardless of how they spent their dole. Housing would be built and supplied to those who could not supply it themselves. Thus one would have all of the good things of life regardless of ability, ambition or work. Such a scheme would be financed by higher taxes. However, as more and more entered the governmental handouts, taxes would go up and up and the endless Spiral would ultimately bankrupt the economy.

Today medicine can see the doorway of a shelter, perhaps dimly but growing brighter all the time. All of us are receiving government money for taking care of military dependents and the senior citizen. We have always taken care of both but today are getting paid better than ever before for doing so. No one would deny that we like it. But what is the next step? More financial shelter for us by enlarging the program?

Medical schools likewise exist and expand on funds from governmental agencies. Research funds and funds from many different governmental programs supply funds for expansion and improvement of the faculties. However it might pay us to stop now and then and try to determine if such a sheltered existence is building a strong physician corps to take care of the ever increasing needs of our growing communities.

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9

When A Onetime MASA President and A Governor Developed TB

Music of the rams' horns brought the walls of Jericho tumbling down. But it took only one glimpse of a yellow flag fluttering in the breeze to stop a Montgomerian's heart from beating.



Dr. Andrews

In those days when epidemics of yellow fever came to the Deep South with frightening regularity, when medical science knew about as much of the disease as it did of "Spanish" influenza in 1918, quarantine was one of the principal weapons against it. And there was something grimly ominous about the drawn draperies and closed shutters of homes from which the warning yellow flag fluttered.

The stricken man, suffering from what was described as a mild attack of the dread disease, had not been told what was wrong with him. A patient of Dr. Glenn Andrews, he was recuperating nicely.

Then one day, feeling the strength flow back into his veins, he ventured to his window and looked out on the beautiful world beyond. Just at that moment a vagrant breeze caught the yellow silk flag and waved it lightly before him.

The patient gasped, clutched his throat, and gently, in slow motion, folded to the floor. He was dead when the doctor arrived.

Just 35 years ago this summer, *The Birmingham News - Age-Herald* ran a full page in the magazine section reviewing in cartoons and terse comments the life of Dr. Andrews, who presided in 1902 as president of the Medical Association of the State of Alabama.

Drawn by Clint Bonner, the popular Alabama cartoonist of the 1930s, the opening cartoon developed the fact that, as the son of a Methodist minister, Glenn Andrews spent his childhood in a number of South Alabama towns (including Auburn and Selma). Educated at Auburn, Vanderbilt, and the medical department of the University of the City of New York, he began his Montgomery practice in April, 1886.

Highlights reviewed in the Bonner feature included his direction of the yellow fever epidemic quarantine, 1897-98, when he also faced as city physician the challenge of the smallpox outbreak of that same time; his organization of the first city and county health department; his influence in outlaw-



Dr. Glenn Andrews and Gov. William D. Jelks, with Mrs. Jelks, seated on porch of a New Mexico sanitarium where the Governor and the Doctor were both recuperating from tuberculosis.

ing old fashioned slaughter pens and public dairies; and his service under five governors as state prison inspector; as well as his 18 years on the State Board of Censors of MASA.

When yellow fever struck in 1897, Dr. Andrews sent his family to Auburn to escape it, and he moved into the home of the then

(Continued on Page 223)

Because any urologic infection can be serious, BREON introduces potent therapy

for the strong start and a fast finish...

"...a significant gap appears to have been closed in the armory of drugs available to the urologist."[1]
Bacteriuria and symptoms can be eliminated within 48 to 72 hours; susceptible infection often in 10 to 14 days.

before your "minor" becomes a major problem

choice initial treatment for urinary infections

Cybis® (nalidixic acid) provides prompt broad gram-negative bactericidal activity at normal urinary pH range that can eradicate troublesome *E. coli,* Aerobacter and Proteus. A good starting drug, it can effectively accelerate management of infection due to sensitive organisms.

essential control within the primary 72-hour cycle

In cases of acute infection due to susceptible organisms, Cybis works well toward the rapid clearing of disease when obstruction is absent or can be relieved. Within 48 to 72 hours, symptoms are frequently eased and bacteriuria eliminated. Susceptible infection is often eradicated in 10 to 14 days.

blocks the young female progression of infection

Cybis can be useful in naturally susceptible young female patients with new or well-established urinary disturbances. Combining rapid potency with relative freedom of serious side reactions and toxicity, the drug can be of particular value in preventing higher tract involvement or blocking the possible continuum of disease. (See Chart)

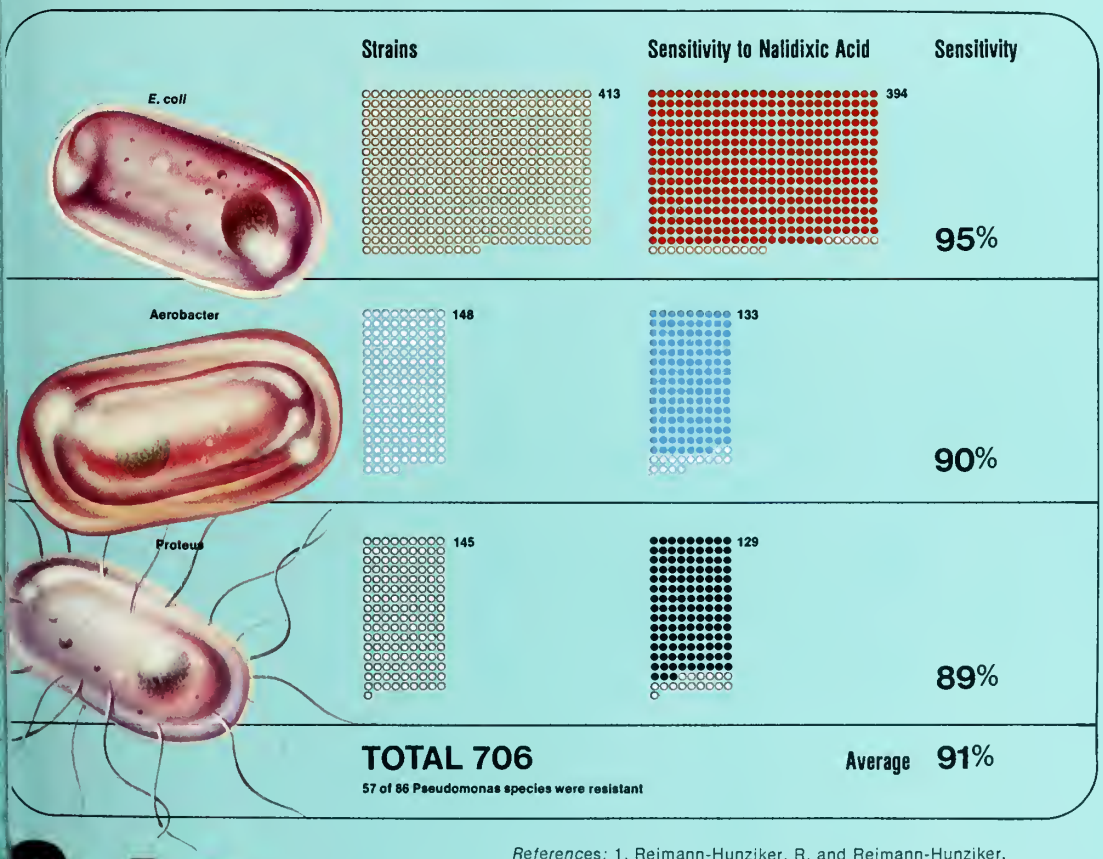
Kinetic Relationship of Acute and Chronic Bacterial Pyelonephritis to Chronic Renal Disease[2]



consistent activity against 706 gram-negative strains

In vitro testing of *E. coli*, Aerobacter and Proteus species showed better than 90% sensitivity to nalidixic acid.[3] (See Table)

Better Than 90% Sensitivity Among 3 Common Urinary Invaders



References: 1. Reimann-Hunziker, R. and Reimann-Hunziker, G. J.: *Praxis* 53:15, Jan. 9, 1964. 2. Sanford, J. P.: *Med. Times* 96:715, July 1968. 3. Reese, L.: *Canad. M. A. J.* 92:394-397, Feb. 20, 1965.

Cybis®
(nalidixic acid)

for the strong start and a fast finish... in cystitis, pyelonephritis, prostatitis, urethritis

Before prescribing, please consult complete product information, a summary of which follows on the next page, including indications, warning, precautions, adverse reactions and dosage.

Summary of prescribing information

Indications: Urinary tract infections in which species of sensitive gram-negative bacteria are predominant, particularly *Proteus, Escherichia coli, Aerobacter, Klebsiella,* and certain strains of *Pseudomonas.* Gram-positive bacteria are less sensitive to Cybis but favorable clinical results have been observed.

Warning: Use in Pregnancy. This drug is not recommended in the first trimester of pregnancy. However, it has been used in several patients during the last two trimesters without producing apparent ill effects in either mother or fetus.

Precautions: Although prolonged treatment with Cybis has been generally well tolerated, as with all new drugs it is advisable to carry out blood, renal, and liver function tests periodically if treatment is continued for more than one or two weeks. The dosage recommended for adults and children should not be arbitrarily doubled unless under the careful supervision of a physician. **It should be used with caution in patients with liver disease, epilepsy, or severe cerebral arteriosclerosis, and in patients in whom kidney function is severely impaired.** Patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving Cybis and, if a photosensitivity reaction occurs, therapy should be discontinued.

During treatment microorganisms may develop resistance to this drug. Resistant bacteria, not previously present or identified, may emerge. Cultures should be taken and bacterial sensitivity tests made periodically, particularly if the clinical response is unsatisfactory or if a relapse occurs. Should resistance develop, other specific chemotherapy should be instituted; no cross resistance has been observed. If new strains of bacteria that are not sensitive emerge, other effective antibacterial agents may be added. When Benedict's or Fehling's solutions or Clinitest® Reagent Tablets are used to test the urine of patients taking Cybis, a false-positive reaction for glucose may be obtained due to the liberation of glucuronic acid from the metabolites excreted. However, a colorimetric test for glucose based on an enzyme reaction (using, for example, Clinistix® Reagent Strips or Tes-Tape®) does not give a false-positive reaction to Cybis glucuronide.

Adverse reactions: Mainly mild nausea, vomiting, and other gastrointestinal disturbances: less frequently, sleepiness, drowsiness, weakness, headache, dizziness and vertigo, and rarely cholestasis, paresthesia, thrombocytopenia, leukopenia, or hemolytic anemia which in some patients may have been associated with deficiency in activity of glucose-6-phosphate dehydrogenase. Itching, pruritus, rash, urticaria, mild eosinophilia, reversible photosensitivity reactions primarily involving exposed surfaces, and reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), occurred occasionally. Reversible increased intracranial pressure with bulging anterior fontanel, papilledema, and headache have been observed occasionally in infants and children. Toxic psychosis and brief convulsions (the latter generally in patients with possible predisposing factors, and both usually associated with excessive dosage) have been recorded in rare instances.

Dosage and administration: *Adults*— Four Gm. dai by mouth (2 tablets of 500 mg. four times daily) for on to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. dai (1 tablet of 500 mg. four times daily). *Children*— According to age and weight: approximately *25 mg. per pound* of body weight per day, administered in divided doses.

Note: The dosage recommended above for adults an children should not arbitrarily be doubled unless unc the careful supervision of a physician. Until further experience is gained, infants under 1 month should n be treated with the drug.

How supplied: Tablets of 500 mg., bottles of 50.

Before prescribing, please refer to complete prescribing information.

Cybis®

(nalidixic acid)

for the strong start and a fast finish...
in cystitis
pyelonephritis
prostatitis
urethritis





BREON LABORATORIES INC.
90 Park Avenue, New York. N.Y. 10016
Subsidiary of Sterling Drug Inc.

(Continued from Page 218)

Mayor John Hughes Clisby. From there he directed the battle against the dread disease. He permitted no trains to stop in the city. Instead they must go to Jackson's Lake, where passengers continued to the capital city by hack.

Believing sanitation an important weapon, he enforced a city-wide cleanup. Householders were instructed to pile trash in the middle of the street from where wagons picked it up and dumped it in the Alabama River.

In 1903 Dr. Andrews developed tuberculosis and was ordered to Las Vegas, N. M.—its existence has been forgotten today, in the shadow of its Nevada namesake!—for rest in the rarefied atmosphere. Gov. William Dorsey Jelks developed the disease and joined him in the resort hospital where the picture of the two of them with Mrs. Jelks, accompanying this article, was taken.

With the conquest of their lung afflictions, the Doctor and the Governor returned to Montgomery, where Dr. Andrews resumed private practice and his position as city physician, as well as for the Western Railway.

On Sept. 1, 1918, Dr. Andrews was appointed by the State Board of Health as State prison inspector to succeed Dr. W. W. Dinsmore, resigned. He served in that capacity under five Governors—Henderson, Kilby, Brandon, Graves, and Miller, resigning at the start of the second Graves administration, after which the position was abolished.

Dr. and Mrs. Andrews celebrated their Golden Wedding anniversary April 27, 1942, less than five months after Pearl Harbor, and he lived two more years, dying before the war ended, in December, 1944. His widow survived him several years, along with a daughter, Mrs. T. Graham Gibson, Marietta, Ga., now of Richmond, Va.; three sons, Glenn Andrews, Jr., now deceased; Air Force Col. J. Warren Andrews, then in command of the Port of Embarkation, Charleston, S. C., now retired as vice president of the First National Bank, Montgomery; and Commander Paul LeGrand Andrews, then on naval duty in the South Pacific, now of Decatur, Ga., along with a number of grandchildren.



when it's late in life and anxiety and depression coexist...

initial therapy

Triavil® 4-10

Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride

maintenance therapy

Triavil® 2-10

Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

appropriate therapy in an appropriate dosage





During the years of declining strength and increasing infirmity, many patients are more sensitive to both the desired response and the unwanted effects of some drugs. That's when low-dosage therapy is needed. And that's when TRIAVIL 4-10, as initial therapy, and TRIAVIL 2-10, for maintenance, can prove particularly useful.

Starting with TRIAVIL 4-10 should help minimize possible dose-related side effects in the geriatric patient with coexisting anxiety and depression. And, subsequently, TRIAVIL 2-10 can increase flexibility in adjusting maintenance dosage.

Activities made hazardous by diminished alertness should be avoided. You will want to inform your patients that the effects of alcohol may be potentiated. Because of the potentiation of other drug effects possible with MAO inhibitors, such agents should not be given concomitantly with TRIAVIL. However, therapy with TRIAVIL can be initiated cautiously two weeks or more after withdrawal of the MAOI drugs. And, until significant remission is observed, close supervision of any seriously depressed patient is, of course, essential to guard against possible suicide. The drug is contraindicated in glaucoma, in patients expected to experience problems of urinary retention, in drug-induced CNS depression, and in bone marrow depression.

TRIAVIL 4-10 & 2-10—tranquilizer-antidepressant therapy especially appropriate for the elderly patient so often intolerant to medication in high dosages.

TRIAVIL®
containing perphenazine and amitriptyline HCl
TRANQUILIZER-ANTIDEPRESSANT

for moderate to severe anxiety with coexisting depression

For additional prescribing information, please see following page.



TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

TRIAVIL 4-10: Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.
TRIAVIL 2-25: Each tablet contains 2 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.
TRIAVIL 4-25: Each tablet contains 4 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.
TRIAVIL 2-10: For use in adjusting maintenance dosage. Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

for moderate to severe anxiety with coexisting depression

INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; urinary retention; pregnancy; glaucoma. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least 2 weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory reponse.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be potentiated.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

SIDE EFFECTS: Similar to those reported with either constituent alone. **Perphenazine:** Should not be used indiscriminately. Use caution in patients with history of convulsive disorders or severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; severe, acute hypotension (of particular concern in patients with mitral insufficiency or pheochromocytoma); skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); grand mal convulsions; cerebral edema; altered cerebrospinal fluid proteins; polyphagia; paradoxical excitement; photophobia; skin pigmentation; failure of ejaculation; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia; significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol), atropine, heat, and phosphorous insecticides. **Amitriptyline:** Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypotension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, blurring of vision, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Before prescribing or administering, read product circular with package or available on request.

MSD | **MERCK SHARP & DOHME**
Division of Merck & Co. Inc. West Point Pa 19486
where today's theory is tomorrow's therapy

Origins of Common Bacteriological Terms and Names

by

Frederick C. Fink, Ph. D.

Pfizer Diagnostics

Words are essential tools. They are also fun . . . to dissect and analyze. On the following pages, the technical vocabulary of bacteriology is examined for origins and root meanings. Unlike many of the older sciences (chemistry, physics, etc.), bacteriology employs terms coined in modern times. As a happy consequence, our words are both wide ranging (from Singhalese to classic Latin to Tulare County, California) and sometimes curiously bizarre (see morgue, parasite, influenza, et al.).

Often the creators of bacteriological terms were explicitly literal in choosing prefixes and suffixes to fit a specific need. Yet others we suspect were being deliberately subtle, and occasionally even downright playful. But our "word-makers" weren't shy about reaching in all directions for descriptive syllables to help them form new terms that would prove both functional and interesting.

The result is that bacteriology is distinctively a "polyglot" science (Greek—polyglottis—many-tongued). This compilation is offered to help bacteriologists realize their "multilingual" status and, with the thought in mind, that it is easier and more satisfying to use a technical vocabulary when you are familiar with its origins.

abortus—Latin—abortus (miscarriage). **Brucella abortus** is the bacterium which causes spontaneous abortion in cattle.

Achorion—Greek—achor (dandruff). A skin fungus.

Achromobacterium—Greek—A (not), chroma (color); Latin—bacterium (a small rod). A bacterium which does not produce pigment.

acid fast—Characterized as retaining dye even in the presence of strong acid.

acidophilus—Latin—acidum (acid) and Greek—philein (to love). A species which thrives in an acid environment.

Actinomyces—Greek—aktis (ray) and mykes (fungus).

Aerobacter—Greek—aer (air, gas) and short form of bacterium (Latin—a small rod). This genus produces gas from fermentable carbohydrates.

aerogenes—Greek—aer (air, gas) and gennan (to make). A gas producer.

agar, agar-agar—Singhalese—agar-agar (a jelly-like substance from sea weed). Used to solidify culture media. It is used in the Orient in soup making . . . . a rash invitation perhaps to ravenous bacteriologists.

agglutinate—Latin—ad (to) and glutinare (to paste). To paste (clump) together.

albicans—Latin—albicare (to be white).

alkaligenes—Arabic—al (the) kali (soda ash) and gennan (to make). Making alkali.

allergy—Greek—allos (other) and ergon (action). Probably refers to the other than favorable action produced on subsequent exposure to a sensitizing substance.

amorphous—Greek—a (not) and morphe (form). Having no defined form or shape.

amphitrichous—Greek—amphi (both) and thrix (hair). Having a hair-like flagellum at each end of the cell.

anaerobe—Greek—an (not), aer (air, gas) and bios (life). Not requiring oxygen for survival.

anthrax—Greek—anthrax (coal). Refers to the red ("glowing coal") appearance of skin lesion in the disease bearing that name.

antibody—Greek—anti (against). A body or unit acting against something else.

antigen—Greek—anti is used here as an abbreviation for antibody with gen (produce).

antisepsis—Latin—anti (against) and sepsis (putrefaction).

artifact—Latin—ars (art) and factus (made). Something made or due to outside influence, and not occurring naturally.

Aspergillus—Latin—aspergillum (a holy water sprinkler used in Church ceremonies). Describes the microscopic appearance of the fungus.

attenuation—Latin—attenuare (to dilute or make thin). To render an organism less virulent.

aureus—Latin—aureus (golden). Refers to pigment produced.

autoclave—Greek—autos (self) and Latin—clavis (key). Automatic "self-locking" apparatus for sterilizing with steam under pressure.

autotrophic—Greek—autos (self) and trophikos (nourishing). Descriptive of bacteria not requiring organic carbon and nitrogen. They "nourish themselves" by synthesizing carbohydrate and protein from inorganic salts and CO_2.

bacillus—Latin—a small rod. Bacillus, the genus of aerobes producing spores.

Bacitracin—Antibiotic discovered by Meleney and Johnson. It was isolated from an organism obtained from a lesion in a child named Tracy.

bacterium—Latin—a small unicellular plant, also a small rod.

botulinum—Latin—botulus (sausage). **Clostridium botulinum** is so-named because is was isolated from contaminated sausage.

Brucella—Genus named for Sir David Bruce, discoverer of the causative agent of undulant fever.

bubonic—Greek—boubon (the groin). Lymphatic swellings are seen in this area in plague cases.

Candida—Latin—candidus (white).

caviae—Derived from Cavia, the generic name of the guinea pig. It has been used as a species name.

cholera—Greek—chole (bile) and rein (to flow).

chromogenesis—Greek—chroma (color) and genesis (making).

citreus—Latin—citrus (lemon). Yellow color.

clinical—Greek—klinikos (relating to a bed).

Clostridium—Greek—kloster (spindle) and idion (small). These bacteria are spindle-shaped when they contain a central spore.

coccus—Greek—kokkos (berry). A bacterium round in shape.

coli—Greek—kolon (large intestine). Refers to normal habitat of an organism.

commensal—Latin—com (together) and mensa (table). "Eating at the same table", or living together.

Corynebacterium—Greek—koryne (club) and bacterium (Latin—a small rod). Refers to the shape of cells seen under the miscroscope.

desiccation—Latin—desiccare (to dry). This frequently misspelled word is easy to remember by noting that the noun form derives from the Latin adjective, sicca (dry). (Non-Latin speaking bacteriologists, if any, can fall back on other desperate mnemonics such as: "One 's' will do—But one 'c' is too few.")

diarrhea—Greek—dia (through) and rhoia (flow). Frequent loose bowel movement.

diphtheria—Greek—diphthera (a skin). This refers to the skin-like membrane formed in the throat.

diplococcus—Greek—diplous (double) and kokkos (berry).

dysentery—Greek—dys (difficult or painful) and entera (the bowels). A painful elimination.

enzyme—Greek—en (in) and zyme (leaven). Yeast cells produce a number of enzymes.

epidemic—Greek—epi (upon) and demos (the people). A sudden onset of disease simultaneously in many people.

Erwinia—Genus name relating to Erwin Smith, early plant pathologist.

erysipelas—Greek—erythros (red) and pella (the skin).

etiologic—Greek—aitia (cause) and logia (study of).

exudate—Latin—ex (out) and sudare (to sweat). This has come to mean passage of any fluid through a tissue.

fibrinolysin—Latin—fibrin (thread) and Greek—lysis (dissolving). An agent which dissolves fibrin.

fission—Latin—fissio (splitting). Bacteria reproduce by their cells splitting to form two new daughter cells.

flagellum—Latin—flagellum (a whip). Lash-like organelle used by certain bacteria in navigation through a fluid environment.

fomites—Latin—plural of fomes (piece of timber). Refers to inanimate objects capable of transmitting "hot" infection.

formalin—Latin—formica (the ant). Formalin is an aqueous solution of formaldehyde. It was from red ants (distilled) that formic acid was first derived.

fungus—Latin—fungus (mushroom). Has a broader meaning today than when originally adopted into the language.

gangrene—Greek—gaggraina (a sore which is necrotic).

glanders—Latin—glandulae (glands of the throat). These are enlarged and indurated in the equine disease.

gonorrhea—Greek—gonos (semen) and rhoia (a flow). "A flowing of semen". One of the few misnomers in our bacteriology vocabulary. The disease obviously was named prior to the discovery of its etiologic agent. It was first thought that the discharge characteristic of the disease was a loss of semen, suffered by the patient as punishment for sexual excesses.

H and O Antigens (Salmonellae)—German—Hauch (a film or membrane) and ohne Hauch (without a membrane). The H antigen is present only in motile organisms because they form a film or membrane of spreading growth on agar. Non-motile organisms (without the membrane) are identified with O antigen, but not with the H antigen.

hemolysis—Greek—haima (blood) and lysis (dissolving). Action on red blood cells by certain bacteria.

Hemophilus—Greek—haima (blood) and philos (liking). Organisms of this genus prefer to grow in the presence of blood.

Herpes simplex—Greek—herpes (a spreading skin eruption) and simplex (simple). Refers to common cold sore.

Herpes zoster—Greek—herpes (a spreading skin eruption) and zoster (a girdle). This eruption encircles the waist and is well named.

heterotrophic—Greek—heteros (other) and trophikos (nourishing). Organisms of this type cannot function as green plants do, but must obtain nourishment from prepared protein and carbohydrate.

immitis—Latin—im (not) and mitis (mild). Pathogenic.

immunity—Latin—immuntas (freedom from financial obligation). Having wandered from its original meaning, this now means exemption from disease.

impetigo—Latin—impetere (attack). This disease usually involves a rather heavy attack on the skin by **Staphylococcus aureus.**

incubate—Latin—in (in) and cubare (to lie).

influenza—Italian—influence. This disease has certainly proved its capacity to "influence" world population.

inoculate—Latin—in (in) and oculus (eye). An ancient agricultural term meaning to graft a bud onto a branch.

Leptospira—Greek—leptos (delicate) and spira (coil).

lyophilization—Greek—lyo (dissolve) and phileo (to love). The completely frozen-dried fraction which results from this process literally "loves to dissolve".

malaria—Italian—mala aria (bad air). So named before discovery of the mosquito vector because the disease was thought to come from swamp air near Rome.

melitensis—Latin—melitensis (of Melita, ancient name for Malta).

mesophilic—Greek—mesos (middle) and philos (liking). Refers to the bacteria which grow best in the medium temperature range.

microbe—Greek—micros (small) and bios (life).

Monilia—Latin—monile (necklace). Refers to microscopic appearance of the fungus.

morgue—French—morguer (to regard solemnly). It is interesting that this term was first used in France for the inner section of a prison where new prisoners were examined.

murine—Latin—murinus (referring to a mouse).

mutation—Latin—mutare (to change).

neutrophile—Latin—neuter (neither) and Greek—philos (liking). Ehrlich in working with dyes and leukocytes found that some cells stained with red granules (acidophilic) and some with blue granules (basophilic). Others showed neither color, and he named these neutrophiles.

parasite—Greek—parasitos (a guest). This further derives from para (beside) and sitos (food).

pathogen—Greek—pathos (suffering) and gennao (I produce or make).

Penicillium—Latin—pencillus (a brush). Refers to microscopic appearance of the fungus.

peptone—Greek—pepton (digesting). Peptone is actually the product of hormonal or other digestion of protein.

perfringens—Latin—perfringens (exploding or shattering). **Clostridium perfringens** decomposes tissue, liberating destructive gases.

pertussis—Latin—per (intensive) and tussis (cough).

phagocyte—Greek—phagein (to eat) and kytos (a cell). These white blood cells devour bacteria and other cells.

pleomorphic—Greek—pleon (more) and morphos (form). Many-shaped.

prodigiosus—Latin—portentous or extraordinary. Formerly the specific name for **Serratia marcescens.** This organism produces an intense red pigment. When it was found growing on Holy Communion wafers, laymen are said to have associated the red color with Transubstantiation (changing into the Body and Blood of Christ), hence **prodigious.**

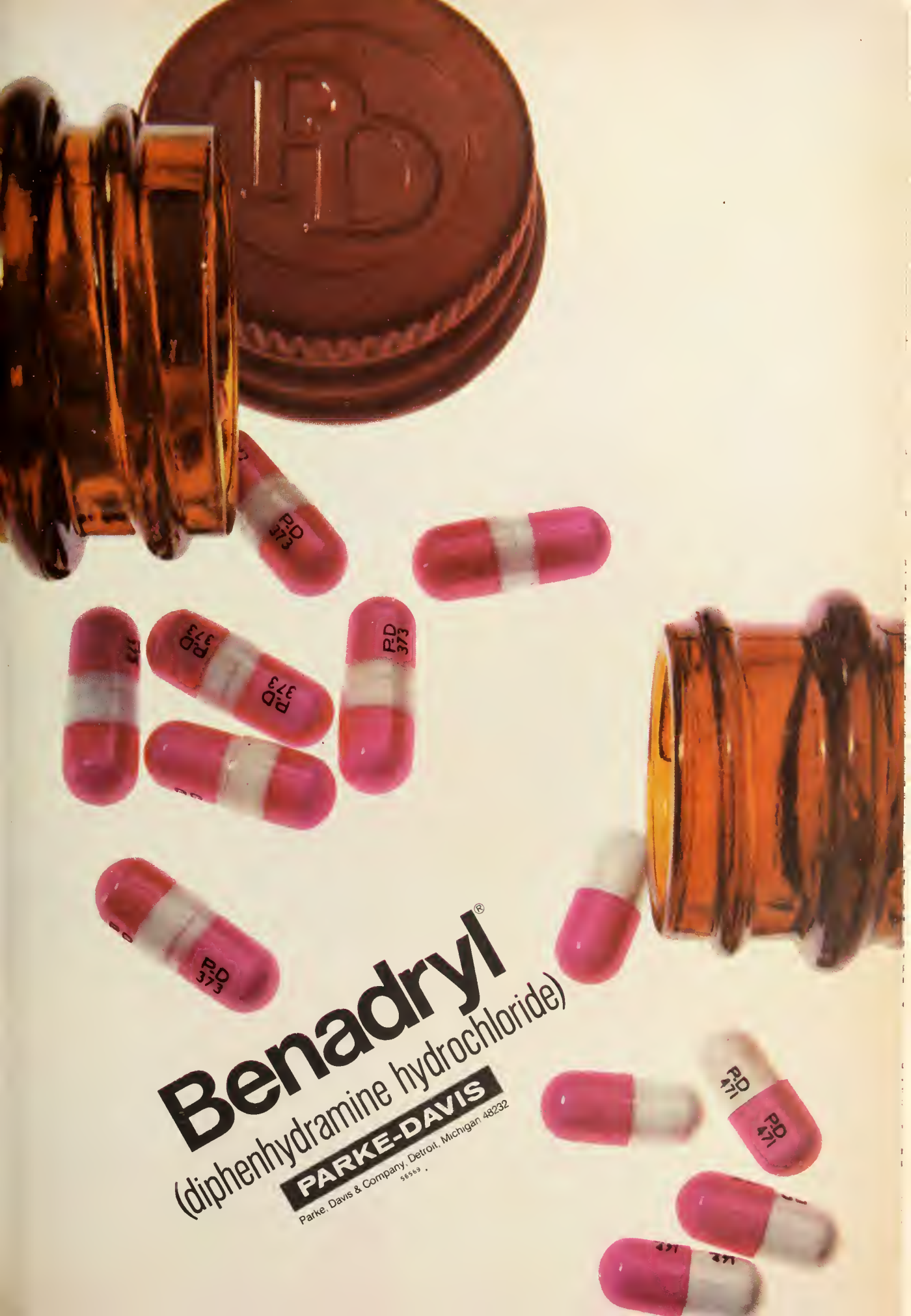
Prcteus—Greek—Proteus (a sea-god in Greek mythology who could change his shape). Young cultures of this genus are quite pleomorphic.

Pseudomonas—Greek—pseudes (false) and monas (single). Organism resembles the single-celled animal known as a monad.

ptomaine—Greek—ptoma (a corpse). Ptomaines, disproven as a realistic cause of food poisoning, are toxic amines produced in putrefaction of flesh.

rabies—Latin—rabio (to rave). Because of central nervous system involvement in this disease, madness can and does occur if untreated.

(Continued on Page 237)


Benadryl®
(diphenhydramine hydrochloride)
PARKE-DAVIS
Parke, Davis & Company, Detroit, Michigan 48232
56569

now he can cope...

thanks to

Butisol SODIUM®
(SODIUM BUTABARBITAL)

the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

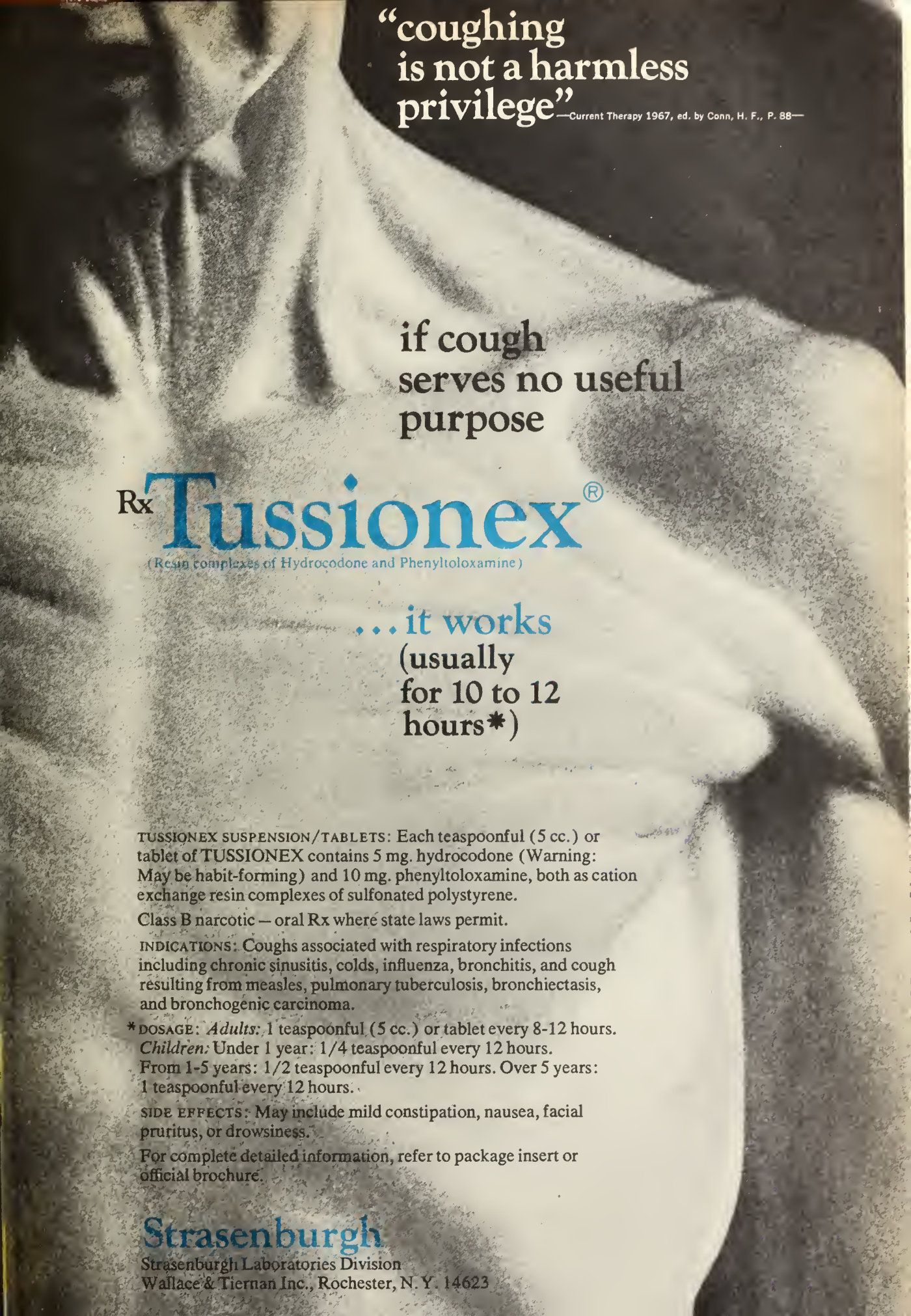
Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).



McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.



TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic — oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N. Y. 14623


No place for beginners

Terramycin®
(oxytetracycline)

Fire victim. Examination reveals second degree burn of lower leg. To combat shock, restore circulatory volume and replace protein loss, plasma is administered. Local pressure dressing applied. Limb elevated to limit the flow of lymph. About 36 hours after admission the patient develops an elevated temperature and complains of pain at the site of the lesion. Dressing removed. A suppurating slough area has developed over part of the burn. A swab specimen is taken for culture and the slough area is debrided. Antibacterial treatment is begun with Terramycin I.M. Days later, recovery is progressing, and the laboratory report shows a mixed infection with a predominance of susceptible coliform bacteria, confirming the therapeutic choice. Terramycin therapy is continued until all signs of infection disappear.

Experience has shown that Terramycin offers special advantages in treating bacterial infections complicating burns, when strains of causative organisms are susceptible. Broad-spectrum antibacterial coverage. Activity unaffected by penicillinase. Rapidly achieved therapeutic blood levels. Proven tissue toleration.

Terramycin I.M. is the only preconstituted broad-spectrum antibiotic designed specifically for intramuscular use. Requires no refrigeration. Remains stable for at least two years. Available for immediate use in Isoject,® a disposable injection unit. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Terramycin® I.M.
(oxytetracycline)



Pfizer LABORATORIES DIVISION
New York, N Y 10017

Contraindicated: In individuals hypersensitive to any of the components of this drug.

Warnings: If renal impairment exists, even usual doses may lead to excessive systemic accumulation and possible liver toxicity. In such patients, lower than usual doses are indicated and for prolonged therapy oxytetracycline serum level determinations may be advisable.

Terramycin may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight. Discontinue therapy at first evidence of skin discomfort.

Note: With oxytetracycline, phototoxicity is not believed to occur and photoallergy is very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy.

As with all intramuscular preparations, Terramycin Intramuscular Solution should be injected well within the body of a relatively large muscle. *Adults:* The preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. *Children:* It is recommended that intramuscular injections be given preferably in the mid-lateral muscles of the thigh. In infants and small children the periphery of the upper outer quadrant of the gluteal region should be used only when necessary, such as in burn patients, in order to minimize the possibility of damage to the sciatic nerve.

The deltoid area should be used only if well developed such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Increased intracranial pressure with bulging fontanelles has been observed occasionally in infants receiving therapeutic doses of the drug, but such signs and symptoms have disappeared rapidly on cessation of treatment with no sequelae.

Adverse Reactions: Subcutaneous and fat-layer injection may produce mild pain and induration which may be relieved by an ice pack. Very mild gastrointestinal disturbances, not requiring discontinuance of the drug, may occur occasionally. Allergic reactions including anaphylaxis, rarely have been observed.

Dosage: *Adult:* The optimal dosage varies, depending on the type and severity of infection. Unless otherwise specified, a dose of 100 mg. every 8 to 12 hours, or a single daily dose of 250 mg. should be adequate for the treatment of most mild or moderately severe infections. In severe infections, 100 mg. every 6 to 8 hours, or 250 mg. every 12 hours may be necessary.

Serum levels obtained by the recommended dosages are comparable to those provided by the oral dosage of 1 to 2 Gm. daily in adults. Antibiotic therapy should be continued for at least 24 to 48 hours after all symptoms and fever have subsided.

In certain diseases specific courses of therapy may be recommended as a general guide. In primary and secondary syphilis for example, the daily administration of 2 Gm. oxytetracycline, orally, in divided doses for two weeks has given good results. In cases of gonococcal infection two intramuscular injections of 250 mg. each, or one intramuscular injection of 250 mg. combined with one gram given orally as a single dose, will usually suffice, but repetition of this therapy will be required in an occasional case.

In the treatment of hemolytic streptococcal infections therapy should continue for at least 10 days to prevent development of rheumatic fever or glomerulonephritis.

In the treatment of staphylococcal infections indicated surgical procedures should be carried out in all cases.

Pediatric: A dosage of 3 mg./lb./day in two doses has been found satisfactory in the treatment of most mild to moderately severe infections. For more severe infections, higher dosages may be indicated and should be adjusted accordingly.

Terramycin Intramuscular Solution provides maximum absorption and patient toleration with minimal local irritation.

Supply: Terramycin (oxytetracycline) Intramuscular Solution: available in single dose, prescored glass ampules containing 100 or 250 mg. oxytetracycline/2 cc. Isoject® syringes containing 100 or 250 mg. oxytetracycline/2 cc. and 10 cc. multiple dose vials containing 50 mg. oxytetracycline/cc.

More detailed professional information available on request



In Gastritis

Also available as Estomul Tablets:

Each swallow tablet contains: orphenadrine hydrochloride, 25 mg.; bismuth aluminate, 25 mg.; magnesium oxide, 45 mg.; aluminum hydroxide-magnesium carbonate (as co-precipitate), 500 mg.

Indications: Peptic ulcer: duodenal, marginal, gastric, esophageal; gastroesophageal reflux; esophagitis (without stricture); irritable bowel syndrome; hyperacidity and dyspepsia; congenital shortening of esophagus with esophagitis; heartburn; spasm of the cardiac end of esophagus; gastritis; symptomatic hiatus hernia; alcoholic gastritis; functional pylorospasm.

Contraindications: Because of the anticholinergic action of orphenadrine, Estomul should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcers, prostatic hypertrophy or obstruction at the bladder neck, achalasia (megaesophagus), and myasthenia gravis.

Precautions: Doses in excess of six tablets or six tablespoons of liquid daily may produce minor side actions such as dryness of the mouth or blurred vision.

Warning: Use of any drug in pregnancy, lactation or in women of child-bearing age requires that the potential benefit of the drug be weighed against its possible hazards to the mother and child. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Side Effects: Possible side actions include: tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, an elderly patient may experience some degree of mental confusion.

Dosage: For adults: One or two tablespoons of liquid or one or two swallow tablets three times daily; depending on severity.

Availability: On Rx only. 12 oz. bottles of liquid and bottles of 100 swallow tablets.

anticholinergic
antacid
demulcent
topical anesthetic

it's all here!

Estomul®
Liquid

Each tablespoon (15 cc.) contains:
orphenadrine HCl, 25 mg.;
bismuth aluminate, 50 mg.;
aluminum hydroxide—magnesium carbonate
(as co-precipitate), 918 mg.

Riker Laboratories • Northridge, California 91324

The Riker Representatives in your area are: Bob Johnson, Bill Phillips, Bill Crabb

(Continued from Page 230)

rugosa—Latin—rugosus (full of wrinkles).

Salmonella—Genus named for the American bacteriologist, D. E. Salmon.

Sarcina—Latin—sarcina (a bundle).

Serratia—Genus named for Serafino Serrati, the Italian physicist. Many pronounce this genus name "Serray-shia", which is incorrect. It should be "Serrat-ia".

Shigella—Genus named for Kiyoshi Shiga, discoverer of the causative agent of bacillary dysentery.

spirochete—Greek—speira (a coil) and chaite (hair).

sputum—Latin—spuere (to spit).

Staphylococcus—Greek—staphyle (cluster of grapes) and kokkos (berry).

Streptococcus—Greek—streptos (twisted chain) and kokkos (berry).

subtilis—Latin—subtilis (delicate).

syphilis—Latin—The name of the shepherd in Fracastorius' poem: "Syphilis Sive Morbus Gallicus." The shepherd contracts the disease, then the mode of spread and treatment is discussed in the poem. This disease, not unexpectedly, has inspired the largest amount of "buck passing" in history. The English call it the French disease, the French call it the Italian disease, etc., etc.

tenue—Latin—tenuis (slender).

therapy—Greek—therapein (treatment).

toxin—Greek—toxikon (poison).

tularensis—Named for a County in California (Tulare) where rabbit fever was first described.

vaccine—Latin—vacca (the cow). Jenner's vaccine made from cowpox lesions was used to immunize against smallpox.

venereal—Latin—from Venus, the goddess of love. Refers to mode of contracting certain infections.

Vibrio—Latin—vibrare (to shake or shimmy). Refers to motility pattern.

virulence—Latin—virulentus (full of virus or poison). Has come to be defined as the disease-producing capacity of an organism.

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: MRS. ELIZABETH HARKINS, ACSW, *Coordinator of Admissions* or

CHARLES W. NEVILLE, JR., M. D., *Assistant Professor of Psychiatry and Medical Director*

Area Code 704 - 254-3201

Fathers and Sons in Medicine

THE WARRENS OF MOBILE

Just 48 hours after the first shock troops of the Allied invasion of Europe struck the Normandy beaches on D-Day, a contingent of doctors went ashore.

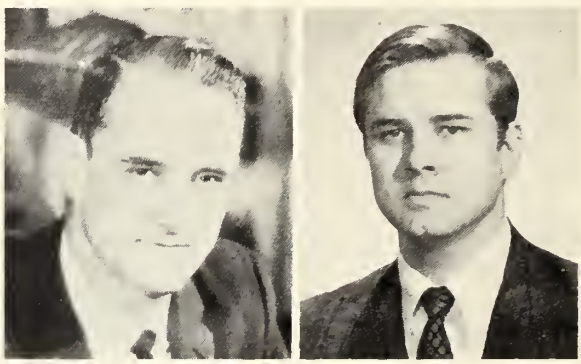
In that contingent was the senior subject of the introductory story about MASA's "fathers and sons in medicine."

He is Claude M. Warren, Jr., born July 31, 1914, in Jackson, Ala., an M. D. from the University of Louisville, Ky., who practices his specialty, OALR-A, in Mobile, and who is president-elect of the American Society of O & O Allergy.

Dr. Warren is married to the former Esther Regan and they have three other children: Jacque (Mrs. Charles R. Butler, Jr.), mother of two sons; Joseph, currently in the University of Alabama School of Business Administration; and Malcolm, married to the former "Sugar" Pettiss, and the father of a son, presently a pre-dentistry student at the University of Alabama.

The younger Dr. Warren, born May 2, 1940, also in Jackson, Ala., an M. D. from the University of Alabama, Birmingham, is interning at St. Vincent's, Birmingham, expecting to continue with an eye residency at the Eye Foundation Hospital there, is married to Carolyn, daughter of Dr. Marshall Eskridge of the X-Ray Department of the Mobile Infirmary. They are the parents of Claude Morris Warren IV and their second child should have arrived by the time this article is printed.

With one exception, father and son have the same hobbies: golf, fishing and hunting; to which the father adds coin collecting, the son photography. When he has completed his residency, a place will be made for the son in a practicing team presently composed of the father and three partners in practice, Dr. Jack Rose Hays, Dr. Jack O. Yeager, and Dr. S. Floyd Fraser.



Drs. Claude Morris Warren II & III

All four of the Claude Morris Warrens are living, the senior of that name still residing in Jackson, the birthplace of his son and grandson.

The World's Paper Explosion

A million pages of new documents are produced every minute, while the copy-machine industry estimates that its machines are disgorging 35 billion copies a year, observes an article on "Combatting the Paper Explosion," published in the Journal of the Iowa Medical Society.

The piece zeroes in on the massive paper work that harasses the medical profession, and suggests that regular cleanups, microfilm, and open-shelf files are helping to solve the problem.

THE HUBBARDS OF MONTGOMERY

Once in history a father and son served in their time as presidents of the United States. Once in history a father and son served as presidents of the American Medical Association. And once in history a father and son served as presidents of the Alabama Chapter, American College of Surgeons.

It is the latter two, Drs. Thomas Brannon Hubbard, Sr., and Jr., who are the subjects here.

Both were born in Alabama's capital city in February, the father in 1887, on the 9th, the son 31 years later, on the 5th. They traveled different routes for their preliminary education, but both were graduated from Columbia's College of Physicians and Surgeons, and both interned in New York hospitals, the senior Hubbard at St. Luke's, his son at Roosevelt. Both, proudly noting their M. D. degrees, served their country in uniform, one in World War I, the other in World War II.

The father practiced medicine in Montgomery from 1912 to 1917, when Army service interrupted his career; but T. Brannon Hubbard, Jr., M. D., (known from childhood as "Bo") returned from war service in a Bath, England, hospital to a promising teaching career at the University of Minnesota, preglimpsing a destiny to which he would return after several years of surgical practice in Montgomery. For the last three years he has been Professor of Surgery in the Medical College of the University of Maryland, Baltimore.

Bo's mother was the late Callie (Clark) Hubbard, whose other three children—Mrs. Fred S. Ball, Jr., the late Mrs. Clauson Ely, and Charles Clark Hubbard—made Montgomery their home from the beginning. Mrs. Hubbard's father was the directing genius who guided the great paper company, Kimberly-Clark, from a modest beginning to an internationally famous corporation.

Bo is married to the former Berry Richards,



Dr. Brannon Hubbard, Sr., with sons, "Bo" and Charles.

the daughter of a native British doctor, whom he met in St. Paul. Their children, in the order of their ages, are Virginia Berry Hubbard, Thomas Brannon Hubbard III, who finished the University of the South, Sewanee, in June; Callie, now pursuing a career in the laboratories at Johns Hopkins; and Fraser, currently a student at the University of Virginia.

The accompanying picture, which bears on its back the inscription: "Father's Day, 1957, compliments of The Promenader and Esther R. Mahoney," is the top half of the photograph of the men in the Hubbard family. Grouped at the feet of the father and two sons are the grandsons, Hubbards and Elys.

The younger son, Charles Clark Hubbard, by the way, is something of a medical phenomenon, in that he survived without permanent injury an enemy bullet of World War II that passed completely through his head, from one cheek-bone to the other, without touching the optic nerve.

Charles is married to the former Henrietta Hill, only daughter of Henrietta (McCormick) and Senator Lister Hill, and they have two sons: Charles Clark Hubbard, Jr., now a student at Indian Springs School, and Lister Hill Hubbard, who completed his studies at the Montgomery Academy last year and will enter Indian Springs in the fall.



Darvon®
Compound-65

Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

Lilly

Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206.

900252

THE JOURNAL

of

THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

Published Under the Auspices of the Board of Censors

Volume 39 September, 1969 No. 3

Laparoscopy In Gynecology

By

D. Erskine Carmichael, M. D.

Description of Laparoscopy

The patient is placed in the Trendelenburg position after the bladder has been catheterized and a satisfactory plane of general anesthesia established. A Verres cannula is inserted into the abdomen near the lower rim of the umbilicus and CO_2 is introduced to elevate the abdominal wall, leaving a pocket of gas betwen the abdominal wall and the viscera. This can usually be accomplished with from 2 - 4 liters of CO_2 allowed to enter the abdomen at the rate of 500 mls. during the first minute and as fast as 1 L/min. thereafter. The laparoscope trocar is then inserted through a 1½ cm. incision made along the lower rim of the umbilicus through the CO_2 injection site. The laparoscope is then placed through the trocar sheath and the examination performed. Manipulation of the uterus and injection of the fallopian tubes may be accomplished by inserting (prior to the procedure) a metal uterine cannula into the endometrial cavity. Better manipulation, biopsy, organ mensuration, aspiration of fluid for cellular morphology and culture, and therapeutic procedures may be carried out through a small abdominal cannula inserted laterally.

* * * * * * * * * *

The gynecologist is often confronted with a diagnostic problem which frequently can be solved or clarified by visual examination of the pelvic organs. Since the popularization of culdoscopy by Decker in the mid-forties with introduction of the knee-chest position, this method of pelvic endoscopy has been the chief one employed in the United States. Although culdoscopy has been utilized principally for fertility or endocrine evaluation, it has, on occasion, been found useful as a diagnostic tool in defining other gynecologic problems, including those associated with gynecologic emergencies. The necessary technical experience of the operator and the utmost cooperation of the patient, however, have led many gynecologists to disregard this procedure in their diagnostic schema.

More recently, interest has been revived in laparoscopy, a method of pelvic endoscopy first described at the beginning of this century. In 1912, two years after Jacobaeus first utilized abdominal endoscopy in the human, Norderstadt, of Denmark, further enhanced the method by introducing gaseous insufflation of the peritoneal cavity and the Trendelenburg position prior to endoscopy. These two innovations increased visualization of the pelvic contents by gaseous elevation of the abdominal wall from the viscera to provide an unobstructed passage for viewing and by gravitational fall of the bowel and omentum cephalad to facilitate exposure of the pelvic structures. The optics were gradually improved, so that at the same time that Decker was espousing culdoscopy in this

Department of Obstetrics and Gynecology, University of Alabama Medical Center, Birmingham, Alabama.

country, Palmer, in Paris, began to perform laparoscopy for similar gynecologic problems and, subsequently, has accumulated a prodigious series of such cases. Palmer introduced a cannula into the cervix for injection of the fallopian tubes, as well as manipulating the uterus during endoscopy. Others manipulate, measure, biopsy and perform minor procedures through a small, secondary abdominal puncture site lateral to the entrance of the laparoscope. The development of the fiber optic laparoscope, permitting the introduction of intense "cold" light, further enhanced its usefulness as a diagnostic, therapeutic and teaching tool.

Through European influence, interest in laparoscopy has been rekindled in this country. During the past 18 months, we have employed laparoscopy as an adjunct to our diagnostic armamentarium at the University Hospital. Its principal advantages over culdoscopy, in my opinion, lie in the broader field of vision afforded, the application of this technique in certain abnormalities which preclude the use of culdoscopy, the removal of otherwise necessary patient participation, and the opportunity of proceeding directly to laparotomy without change in patient position. Since CO_2 is more rapidly absorbed from the abdominal cavity than air, there is also a decreased incidence of postop shoulder pain.

We have employed this procedure principally for endocrine and fertility evaluation, though it has provided diagnostic information in other problem cases, such as congenital anomaly of the vagina and undiagnosed or misdiagnosed pelvic pain in which endometriosis, non-clinical P. I. D., tubal pregnancy and pelvic congestion syndromes have been found. We have not performed therapeutic procedures via this route, as have been reported by others, since we do not feel that this method is preferable to laparotomy in those instances.

A by-product of gynecologic laparoscopy is the ease with which many other intraperitoneal structures may be examined before the procedure is terminated. These include liver, gall bladder, stomach and, often, the appendix. The anterior peritoneal surface is also readily scrutinized. For many years, internists, especially gastroenterologists, have utilized laparoscopy, employing local anesthesia at the bedside or examining table. The Ruddock laparoscope is named for a well-known California gastroenterologist, who, before his death in 1957, performed over 2,000 such examinations.

Complications are few and generally minor. Our problems have been chiefly those of entering the abdominal cavity in obese patients (a longer trocar has now been obtained for this purpose) and three instances of B. P. decrease. The marked fall in blood pressure which occurred during CO_2 insufflation in one case was easily corrected. The hypotension was thought to have been produced by reflex vagal stimulation from peritoneal stretching. It was accompanied by bradycardia. Subsequent laparoscopy was performed without difficulty. This case has prompted us to increase preliminary atropine administration from 0.4 to 0.8 mgm. Although this dose is rather small relative to vagal inhibition, we have not noted recurrence of hypotension since instituting this regimen.

In summary, laparoscopy may be exceedingly helpful in delineating the bases for many diagnostic gynecologic problems. Technique is readily learned, generally easy to perform and associated with few complications. It is the only method of pelvic endoscopy possible in cases of obliteration of the cul-de-sac, certain congenital anomalies of the vagina, or when an area above the broad ligament is to be examined.

The Department of Obstetrics and Gynecology at the University of Alabama Medical Center will be happy to receive any laparoscopy candidates on referral and extends to any interested obstetrician-gynecologist an invitation to observe and participate in laparoscopic examinations.

Immunologic Augmentations For Learning And Psychiatry

Wallace Marshall, M. D.

Montgomery, Alabama

Several recent articles[1,2,3] in this series stressed the importance of learning for the development of one's education, frustrations, complexes and possible psychotic states. An intact nervous system, through its afferent components, encode or imprint the receptive cortical cells to one's environment. The dosage of cortical stimuli appears to determine the degree of cortical encoding. Excessive amounts of such stimuli may produce what the late Clark Hull termed "overlearning." This is another way of stating that these brain recipient centers have become hypersensitized to such stimuli. Our consideration of such immunologic implications with learning form the crux of this communication. The effects from previous learning episodes can be of paramount importance, particularly where similar or related afferent stimuli bombard such previously sensitized cortical input centers. This phenomena becomes a part of an immunologic reaction. The memory phenomena are able to recognize previous sensitizations caused by previous encoding from psychoallergens (afferent stimuli). Such is the basis for learning. If learning cannot take place for various reasons, then the individual remains amential. Interruption of all five perceptive tracts or the lack of a properly operating encoding brain cell apparatus may produce such a phenomenon.

On the other hand, if an individual has marked ability for imprinting (learning) and storing all he perceives, he may possess a high intelligence quotient, and might function brilliantly intellectually. If he can recall or release the stored brain cell potentials upon volition and use his other associated encoded brain centers freely through association tracts with their myriads of synapses, he may function more efficiently by what can be regarded as cerebration (thinking). The process of learning usually embodies all of these cortical functions of receiving (encoding), storage, (memory) and recall (with the association of "ideas"). This latter process seems to be associated with cortical recognizing of a psychoallergen to the encoded and stored information in particular brain cells as the result of learning from previous related stimuli (psychoallergens). This is termed recognition and appears to be related intimately with recall and one's ability to create new concepts. Arthur Koestler has written extensively on this matter of creativity[4] with his concept of brain matrices and how these might combine to form original ideas.

Relativity of Immunologic Factors in Learning and Psychiatry

A. General denominators. Some years ago, a comprehensive study[5] was performed on this subject. Perhaps the only change which the passage of time produced was the omnipresent tendency to prefer different nomenclature in diagnosing psychotics. However, the results from this study remain basically unchanged. The role of heredity seemed to play a more dominant part in allergic conditions than with the psychoses. The age of onset with allergies had a greater percentage of patients in the first decade than did psychotics.

The factor of sex with allergic patients and also the insane shows variance. Pubertal and menopausal changes were prominent in producing increased incidents in both allergic and insane individuals.

Allergic and psychotic patients appeared to show similar types of onset. The matter of

periodicity appeared similar in these diseases, while the degree of severity in both disorders seemed to influence prognosis. Both diseases were affected markedly as to their health status. Low resistance caused an increase in the individual's liability to either disorder.

The psychic factors appeared to play an important role with both types of disorders, and the multiplicity of sensitivity was inherent with both diseases.

Intercurrent diseases may produce clinical improvement with both maladies, while sensitizing and provocative doses of antigens and/or psychoallergens may or may not enhance such diseases. The sites of reactions in both disorders appear to be identical and they may operate on the same *modus operandi.*

Eosinophilia might occur in both types of diseases. Finally, Jegorow's laws of allergy[6] appear to have exact counterparts in various psychopathologic disorders.

B. Specific denominators. Fish are the lowest forms of life phylogenetically which are able to develop anaphylaxis and hence, Prauschnitz-Kutsner autibodies. Excessive amounts of these P-K antibodies can produce possible anaphylactic shock and death. Excessive emotional reactions, such as intense fright, have been known to whiten a man's hair overnight, or produce syncope or even shock in some people. An example of such a reaction can be produced in a caged rabbit who is placed near a cage containing a large snake. The rabbit will usually die of fright.

Using allergic and immunologic principles as described in several textbooks on these subjects,[7,8] we shall demonstrate the associations which appear to exist between immunology, learning and psychotic states.

The matter of sensitivity is of particular importance in allergy and immunology. Certain allergens and antigens are capable of producing hypersensitivity in certain individuals to such agents. Such reactions are not found in non-sensitive individuals. This property of sensitivity is also the main characteristic of the nervous system which responds to stimuli in normal subjects. This ability keeps the organism in touch with its environment so it can adjust properly to changing environmental situations. Without sensitivity to stimuli, the nervous system and the immunological mechanisms would become non-active and unreactive.

From the aspect of ontogeny, significant amounts of antibodies only appear after birth. This finding corresponds to the neonate's ability to learn properly. So far as antibody production is concerned, IgG antibodies appear from four to six weeks following human birth. This is approximately the time when human infants begin to perceive stimuli from their environment, and the learning process begins to function. Nelson[9] states that the infant can fix his gaze on a light or some other bright object and follow this object with his eyes for a few degrees from the line of his vision within a month's age. He can follow it through an 180 degree arc by the end of the second month when eye and hand coordination develops also. The infant may reach for and hold an object briefly by the end of 12 weeks. Perhaps the most important infantile progress is registered within eight weeks when the infant smiles as the result of his social contacts. These human reactions result from the infant's learning mainly through what he sees, hears, tastes and feels.

The Montessori teaching method appears to have much merit, since it attempts to reinforce environmental stimuli through the sense of feel. This same approach was employed with the famous case of Helen Keller. Tactile stimuli and their value in infant learning appears to have been overlooked until comparatively recently. Most parents may recall their infantile offspring putting every nearby object in their mouths. They were learning the nature of those objects from tactile stimuli. Similar behavior can be observed with puppies who seem to delight in tasting and chewing on every con-

ceivable nearby object to become acquainted with its characteristics and thus sensitize the recipient cortical centers through this imprinting process known as learning.

Recently a TV commercial depicted Buddy Hackett as a space man, emerging from his space craft. He seized a package of potato chips and eagerly attempted to stuff them in his eyes, nose, ears and finally into his mouth. He then expressed marked satisfaction as he munched them and uttered sounds of pleasure. Perhaps this is a crude way of depicting the learning process, and I wonder if the Madison Avenue hucksters realized the scientific nature of their commercial.

Some tots appear to favor learning mainly through vision, while others seem to learn more proficiently through hearing and/or the tactile (touch) sensations. Early recognition of these preferred pathways for learning are highly important. Each child should be tested to determine the exact nature of his sensoria and the child's neural pathway preference concerning the ability to learn. The early recognition of possible sensory defects will pay off handsomely in later life, particulary when the children reach school age. Obviously, hereditary factors favor certain neural and brain proficiencies as weil as the various neural and brain deficiencies as with dyslexia (alexia). With the present learning methods, all children are taught with one rigid procedure, which, in itself, is not too physiologically sound.

Prompt early diagnostic procedures for possibly deficient afferent and cortical neural pathways may do a great deal to locate and correct such deficiencies at the earliest opportunity. If such corrective measures become delayed, or if possibly questionable therapeutic procedures are employed by improperly trained personnel, further damage may result in these affected children. Furthermore, some of these remedial procedures have not received expertise ratings by qualified scientists and medical clinicians. Moreover, some of these questionable therapies have proved to be exhorbitantly expensive so that only very wealthy parents can properly finance such work and gain advantage therefrom as a type of status symbol. One cannot turn back the clock with the ontogeny of any individual so that current training will compensate for that allegedly missed during one's neurologic development. However, reeducative therapies which substitute a properly functioning afferent neural tract for a deficient one does make much sense. Such was employed with marked success in Helen Keller's case, for cases with Parkinsonian syndromes, [10, 11] multiple sclerosis,[2] Morvan's disease[13] and other neurologic disorders.

It is known that premature infants form fewer antibodies than do normal infants. A parallelism might also exist with the lack of proper neural maturation so they might learn as do normal infants; whether the placental barrier has anything to do with these ontological processes is not known presently.

The opossum develops antibodies around the 20th day of gestation. It would be interesting to learn if this process is related in any manner to the recognition of fetal stimuli (in utero). A relationship is known to exist between antibody formation and the development of lymphoid tissue. All this may later be shown to also correspond to the recognition of fetal stimuli which can be regarded as a very early stage with the learning processes in such animals. A definite correlation exists in the decline of antibody formation in the human with a similar decline in learning ability around the age of 60.

Immunologically immature animals are presumed to acquire immunologic tolerance to intrinsic "antigens of self" which are capable of producing autoimmune diseases such as Hashimoto's thyroiditis, lupus erythematosis, immune hemolytic anemia and experimental allergic encephalomelitis. Some observers think that certain types of idiocy may be related to the formation of autoimmune bodies *in utero* or during an early age neonatally.

Heath's Views on Schizophrenia

One of the most encouraging series of recent studies on this baffling psychosis has come from Heath's laboratories at Tulane. He views this disorder as caused by structural changes produced by ataraxin. This pathologic substance appears to be generated by faulty predetermined genetic factors.[14] Heath stresses the concept that a person's behavior is produced from his previous experiences, such as memory which is caused as the result of sensory perception. This is exactly what the Psychoallergic theory stresses. The individual, so states Heath, is programmed by his early environmental stimuli which produce his experiences. Heath believes that ataraxin, obtained from schizophrenic patients, may be "antibody to unique antigenic sites of the septal region" in such patients. Incidentally, Heath is one of the very few psychiatrists who has mentioned the importance of learning, per se, in the genesis of mental disease.

Concerning brain antigens, Mihailovic and Jankovic[15] made immunologic techniques possible in studying brain macromolecules. Edelman and McClure used general fractionates of antigenic components in aqueous rat brain extracts. They found that the serum proteins were superior antigens (immunogens) than whole rat brain extracts. Electrophoresis of rat brain extracts against rabbit antiserum yielded eight to 12 brain antigens. But Bogoch discovered a minimum of 13 brain antigens with the use of immunoelectrophoresis.

Concerning a possible explanation for the various psychologic processes, Schmitt proposes an interesting viewpoint.[16] A gene (or RNA polymerase) is activated by ionic fluxes which are associated with excitation processes which act on the cell membrane area where sensory input impinges. This produces a permanent change in the membrane and forms a basis for feedback and recall. This model may serve as a chemical basis for psychologic phenomena, for these brain macromolecules may serve as the sources for fixed charges on membrane surfaces which may be responsible for electrokinetic phenomena. These macromolecules may be the sites of impedance changes which accompany physiologic transients which include the storage of stored information (resulting from encoding).

Primary and Secondary (memory) Responses to Antigens

A primary response to an antigen occurs possibly with the formation of antibodies to that antigen. When a second dose of the same antigen is administered months or even years later, an accelerated and intense bodily reaction occurs which is termed the "specific secondary response" or the "memory response." These two forms of reactions occur with the administration of a specific antigen. Apparently the body recognizes the specificity of the particular antigen employed with each dosage of the particular antigen.

A similar counterpart can be observed with the primary introduction of a sensory stimulus (psychoallergen). When an additional dose of the same type of stimulus is reintroduced, additional, rapid learning may ensue. Perhaps the encoded cortical cells recognize the additional dose of related psychoallergen and reinforced learning takes place.

It is of interest to recall that antibody response diminishes with the age of the individual as does the ability to learn, especially in people past 60, as has been mentioned previously.

Anamnestic Response

This term was employed to denote the "recall production" of antibodies which are supposedly specific for one antigen through the administration of an unrelated antigen. Recent findings now suggest that these antibody responses are specific reactions to specific or closely related antigens which act on similar antigen determinant sites. Although not readily evident in nature, this

anamnestic response is a protective one which undoubtedly occurs and cannot be overemphasized as to its importance.

Also of major importance is the size of the primary antigenic or psychoallergenic dose. This reaction may well determine both the intensity and the period of longevity for memory. As an example, intense fright produced by a snarling canine during childhood may rapidly hypersensitize the child's cerebral cells which may well result in marked imprinting and which may become lifelong in length so far as being afraid of dogs.

From a therapeutic viewpoint, desensitization of such a hypersensitized state can take place through what Wolpe[17] has termed reciprocal inhibition, which is really a form of desensitization. As with the above situation with the dog, small doses of psychoallergens (seeing the dog) are introduced to the phobic child. The dog is brought closer each time until the child's fears are allayed and he can pet the dog. This identical procedure was employed by the writer recently with a playmate of my daughter. This lad became hysterical every time our puppy happened to be nearby. He became desensitized to his fear with the passage of time until the dog and he became close friends.

A similar reaction and its therapy has been experienced by this writer and his surgeon father. During childhood, we both experienced nausea at the sight of blood. However, later in life (during medical school) we both gradually became desensitized to this fear. However, we both have mentioned that this feeling of nausea returns at the sight of blood, and we have found it necessary to keep desensitized by periodically partaking in some operative procedures. I have been told that such reactions are not too rare among some surgeons who also have experienced hemophobia.

Antigenization and the Latent Period

This reaction occurs when antigens react by producing antibodies. Antigens may or may not incite specific antibodies. We can regard antigenization as taking place during the encoding process in the cortical cells as the result of psychoallergenic introduction.

A latent period occurs usually several days between antigenization and the acquisition of tolerance with its antibody formation. This phenomenon has been also called immunologic tolerance, tolerance, antigenic paralysis, immunologic suppression, antigen tolerance and also immunologic unresponsiveness. It is supposedly caused by the failure of the antibody response to an antigen following the exposure to antigen. In other words, this tolerance is produced from prior exposure to antigens or closely related antigens.

A correlation appears to exist with the process of learning. For example, a bloodhound will not track if he has not been taught to use his marked sense of smell for recognizing human odors. But once the bloodhound is taught (perceives human scents) he shows marked ability to track. This is another example of perceptual reinforcement of learning.

However, certain canines show a different reaction to learning which might well be associated with inherited abilities. The pointer remains rigid as he points at a bird. Such a latent reaction might be associated with a latent period such as accompanies antigenization.

In a previous paper, the latent period was exemplified by the frozen positions taken by fighting cocks as they face each other, or by the periods of catatonic-like rigidity observed with cats during the times they are engaged in stalking their prey.

Psychologists have been baffled by this most intriguing phenomenon. Hebb[18] called this the "autonomous central process." But other terms are set, purpose, insight, attention, attitude, need, vector, preoccupation, perservation, expectancy, hypothesis and other terms. Hebb considers this phenomenon as a recognition that responses are determined by something else other than the im-

mediately preceding sensory stimulation. Hull considered it as a stimulus trace set up by a lasting cerebral state, produced by some specific stimulus which is not transmitted nor abolished immediately. This reaction certainly affects behavior, but it is not a part of an afferent stimulus according to Hull's conception.

Hebb's point is that neural excitation in itself does not explain set. In this writer's opinion, the psychologists are trying to explain the refractory state which has been described in this paper. This lapse in overt behavior is readily explained in immunologic terms, as when previously sensitized cortical cells (previously encoded), now recognize an influx of associated neural stimuli (psychoallergens) and become refractory temporarily so far as observable behavior is concerned. In other words, the refractory period or set results from a sensitizing process in the affected cortical cells in both psychologic and/or immunologic states. Such is observed commonly whenever an individual is confronted with overwhelming doses of afferent stimuli (psychoallergens) which bombard some previously sensitized cerebral area and renders the individual to become speechless (overwhelmed by the marked influx of associated psychoallergens). Also, such a refractory state in animals and birds, which are overcome by fright, might allow for their capture by predators.

Higher animals have the capacity to develop antibodies against a near infinite number of foreign bodies (antigens) regardless of whether they are harmful or not. It is assumed that a near infinite number of psychoallergens can either sensitize or hypersensitize the brain cells similarly, depending upon the size of the afferent dosage and whether or not the encoding cortical cells have been sensitized previously by allied psychoallergens, in other terms, if some learning has occurred previously.

Antigen Competition

Although other considerations remain in our current comparisons between immunologic concepts, learning and psychiatric behavioral aspects, antigen competition will be our final topic during the present series of four articles.

It is known that when two or more antigens are introduced at or near the same time, the antibody response to one or more of these antigens may be repressed. This appears to also be the case when two or more afferent factors (psychoallergens) are introduced to an individual. Usually one will be dominant so far as learning is concerned. For example, a dose of psychoallergen via the visual tract may prove to be more dominant than a dose of psychoallergen via the auditory tract. Or this may be reversed in other individuals. Such preference may be related to one's inate abilities because of hereditary factors, the state of health in these individual neural pathways and cortical areas, or because of other factors which are involved with the study of aptitudes.

However, antigen competition takes place usually when a strong antigen or psychoallergen is administered in a large dose hours or days before another similar antigenic dose is given. Strong antigens or psychoallergens appear to be more competitive than weaker ones. Hence, the dosage, strengths, and the previous introduction of the competitive antigen or psychoallergen, with the time element, strongly affect the host's type of reaction to their introduction. One's genetic factors also play highly important roles in the host's reactions as do various environmental aspects. Finally, various marked quantitative and qualitative responses to antibody formation result from antigens even in different individuals of the same or different species. All antigens do not elicit uniform immunologic responses. But the absence of a proper bodily response to a virulent antigen or psychoallergen may eliminate that individual from the population.

Perhaps future studies in psychology and psychiatry have need for incorporating immunologic concepts for their serious consider-

ation. Neurologists found it highly expedient to include the reading of roentgenologic findings for proper neurologic diagnosis. There is great need for the serious consideration of immunologic reactions in psychology and psychiatry. Under the aegis afforded by the study of immunology, psychiatry might again become an integral part of the encompassing field of neurology. What a gala day that may become for the rapid advancement of medicine and science, for learning, with its normal and abnormal implications, might cease to be a dirty word for many psychiatrists!

1602 Pine Needle Road.

References

1. Marshall, W.: Learning and the development of frustrations. Jour. Med. Ass'n. St. of Ala. 38:622-625 (Jan.) 1969.

2. _____: Theory, learning and origin of complexes. Jour. Med. Ass'n. of St. of Ala. 38:916-921 (Apr.), 1969.

3. _____: Normal and abnormal behavior from learning. Accepted for publication by Jour. Med. Ass'n. of St. of Ala.

4. Koestler, A.: The Act of Creation. The Macmillan Co., N. Y. 3rd printing, 1964, p. 45.

5. _____ and Tarwater, J. S.: Comparative study of etiologic factors in allergic and psychopathologic conditions. Va. Med. Monthly. 65:154-162 (Mar.), 1938.

6. Jegorow, B.: The laws of allergy. Winer Klimische Wochenschrift 49-623, May 15, 1936.

7. Sheldon, J. W., Lovell, R. G., and Mathews, K. P.: A Manual of Clinical Allergy. W. B. Saunders Co., Phila., 1967.

8. Weiser, R. S., Myrvik, Q. N. and Pearsall, N. N.: Fundamentals of Immunology. Lea and Febiger, Phila., 1969.

9. Nelson, W. E.: Textbook of Pediatrics. W. B. Saunders Co., Phila. 8th Ed., 1964, p. 25.

10. _____: Psychopathology and treatment of the Parkinsonian syndrome and other post-encephalitic sequelae. Jour. Nerv. and Ment. Dis., 84:27 (July), 1936.

11. _____ and Marshall, V. F.: Traumatism and parkinsonismus. Jour. Med. Ass'n. St. of Ala. 6:358-362 (May) 1937.

12. _____: Psychologic observations with reeducation in a case of multiple sclerosis. Arch. Physical Therapy 21:164 (Mar.) 1940.

13. Case from author's files.

14. Heath, R. G.: Schizophrenia: pathogenetic theories. Internat. Jour. Psychiatry 3:407-410 (May), 1967.

15. Neurosciences Research Program Bulletin Dec. 31, 1965, p. 10.

16. Schmitt, F. O.: Molecular parameters in brain function. In the Nobel Conferences "The Human Mind," North-Holland, 1967 (organized by Gustavus Adolphus College, St. Peter, Minn.)

17. Wolpe, J.: Psychotherapy by Reciprocal Inhibition. Stanford Univ. Press, Stanford, Calif., 1965.

18. Hebb, D. O.: Organization of Behavior. A Psychological Theory. John Wiley and Sons, Inc. N. Y., 1st Science Edition printing, 1961.

Reflectorized Tags For Children Urged As Safety Measure

EVANSTON, ILL.—The American Academy of Pediatrics has strongly recommended that retro-reflective materials such as reflectorized tags attached to a child's coat zipper be worn by children at night. This, the Academy emphasizes, will help to significantly reduce the more than 1,000 childhood deaths attributed each year to poor visibility during evening hours.

In a statement appearing in the July 1 AAP *Newsletter,* the Academy Committee on Accident Prevention encourages the development of various commercial reflectorized material to make pedestrians readily visible to drivers at night.

Retro-reflectorized materials, the Academy statement emphasizes, can either be affixed to clothing, or incorporated in the design of a garment.

The Academy further recommends that more information concerning traffic safety be given to pediatric patients.

The American Academy of Pediatrics has more than 10,800 members in the United States, Canada, and Latin America.

nursing care for cancer patients–

...a major concern for their families, *and* for their physicians. In a unique pioneering service, the American Cancer Society is deeply involved in finding a solution.

Recognizing the phenomenal growth of nursing homes—aware of the shortage of nurses—knowing the implications of the extended care benefits of Medicare—the Society has launched a dramatic educational demonstration project on cancer nursing for nursing home staff. Special emphasis is on colostomy irrigation, care of the laryngectomized patient, care of an ileal bladder, and emergency nursing. To achieve maximum application of this plan, a cadre of nurses is being trained by the Society to conduct cancer nursing courses in nursing homes throughout the nation.

This endeavor has been warmly endorsed by the American Nurses Association and other professional organizations. We feel sure that such a program, bringing skilled nursing care to the bedside of the cancer patient, will be enthusiastically received by the medical profession.

AMERICAN CANCER SOCIETY®



THIS SPACE CONTRIBUTED BY THE PUBLISHER

AMERICAN CANCER SOCIETY ALABAMA DIVISION, INC.
1025 SOUTH 18th STREET
BIRMINGHAM, ALABAMA 35205



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

NOW IS THE TIME... TO GIVE HER TIME WITH OVULEN-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.



The new mother needs time . . .
to adjust to motherhood,
to give her new baby all the love
and attention he requires.
She needs time for her husband . . .
and for herself as well . . .
so that she can come to terms
with the increased cares
and responsibilities now facing her.
She needs time to decide
when she will have additional children
and how many she will have.

OVULEN-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

GIVES HER TIME

Your prescription for Ovulen-21 gives the new mother time to meet her family's present needs...to plan for her family's future.

She can take Ovulen-21 confidently and comfortably month after month. Its dependability is enhanced by its simplicity of use. A woman needs little or no time to learn the simple Ovulen-21 regimen: three weeks on—one week off. And the automatic record-keeping of the petite, virtually "patient-proof" Ovulen-21 Compack® helps to maintain her schedule...helps put time on her side.

Immediately post partum is the time

It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

It is also the most opportune time, since she is conveniently present in the hospital, for her to be given both instructions and a prescription.

Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Controceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestagen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching. The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromaphtholein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.



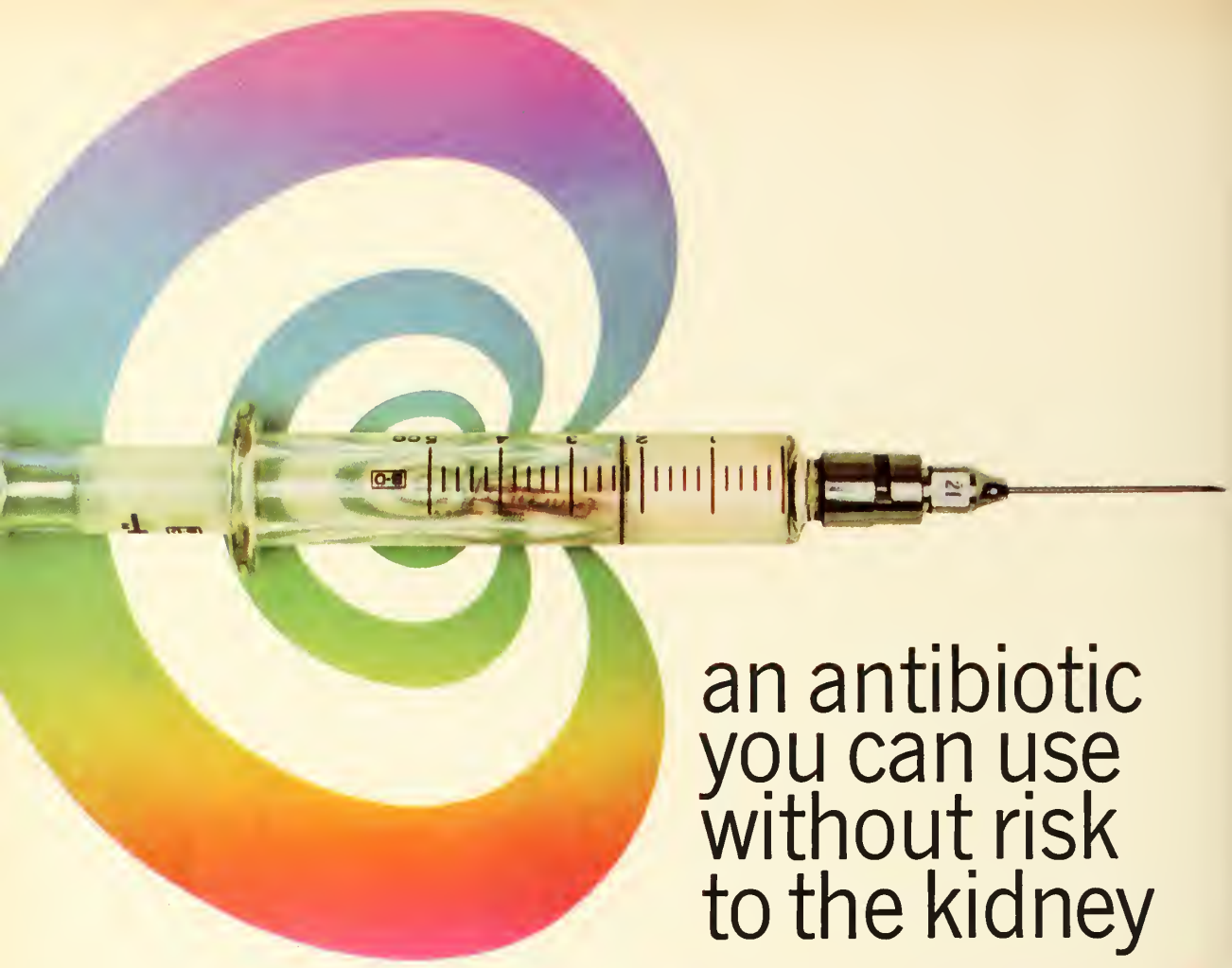
References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see complete prescribing information.

Where "The Pill" Began

G. D. SEARLE & CO., P.O. Box 5110, Chicago, Ill. 60680 SEARLE

972



an antibiotic you can use without risk to the kidney

Polycillin-N®

(sodium ampicillin)

the penicillin you use like a broad-spectrum antibiotic

PRESCRIBING INFORMATION. 11—1/2/69. For complete information consult Official Package Circular.

Indications: Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli, H. influenzae, P. mirabilis, N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).

Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.

Precautions: Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.

Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis—150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.

A.H.F.S. Category 8:12.16

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



Medicaid Payment For Individual Practitioners--- A Definition

Effective July 1, 1969 (and published in the Federal Register for that date), HEW established regulations in effect freezing maximum state payments under Medicaid for "individual practitioners services"— including services of physicians, dentists, and other "individual practitioners."

Query: The precise meaning of "individual practitioner services" is not defined. This may simply be a distinction from institutional services, but might exclude, for example, members of prepaid groups.

The regulation on reasonable charges published Jan. 25, 1969 (45 CFR 250.30) remains in effect except where inconsistent with the July 1 regulation. That regulation's limitation of payments for non-institutional services to the individual provider's customary charge, within the prevailing charge in the community, appears to remain in effect.

The July 1 regulation affects only payment for services rendered after June 30, 1969; it is not retroactive to services provided before that date, even if not yet paid for.

It does, however, limit the amount the state can *pay* within the Medicaid program, not simply the amount eligible for Federal matching. If the state payment exceeds the Federal ceiling, no Federal matching is available.

In almost all programs now in operation (43 of 44), payments must now be limited to the amount payable under Medicaid or Medicare-B (whichever is less) on Jan. 1, 1969.

The 44th program, Virginia, was approved effective July 1, 1969. For its program, the ceiling on payments is fixed at the lesser of the Medicaid or Medicare-B amounts as of July 1, 1969.

In the remaining ten states which do not now have a Medicaid program, payment structures will be governed by the criteria listed in the section of this report labeled "Future."

In addition to freezing maximum payments at the Jan. 1 (July 1), 1969 level, state plans must include a description of the state's payment structure.

No one payment mechanism is required. If the state bases its payments on *usual, customary, reasonable, or prevailing charges,* it must define the terms and explain how in-

dividual customary charge and other charge information is obtained, and must list maximum payments allowed for the most frequent procedures. If a *fixed fee schedule* or a *maximum schedule of allowances* is used, the schedule itself must be included in the state plan. If a *relative value study* schedule is used, a published study must be used and identified in the plan and the conversion factor or factors must be listed.

All plans, now operating or approved in the future, must include (as applicable) any variations in the payment structure required for different geographic areas, medical specialties, or special circumstances (examples given in the regulations are hospital-based practitioners and nursing home visits).

FUTURE

Existing Medicaid Programs

After July 1, 1969, any change in the payment structure sought by the states from the mandated level described above must be approved by HEW before it can become effective.

In its application for such a change, the state must include an estimate of the percentile of the customary charge range the revised structure will cover, and explain its method of estimating the percentile. It must list the maximum allowances for the most frequent procedures, and estimate the "composite average percentage increase" of the new fee structure over the current one.

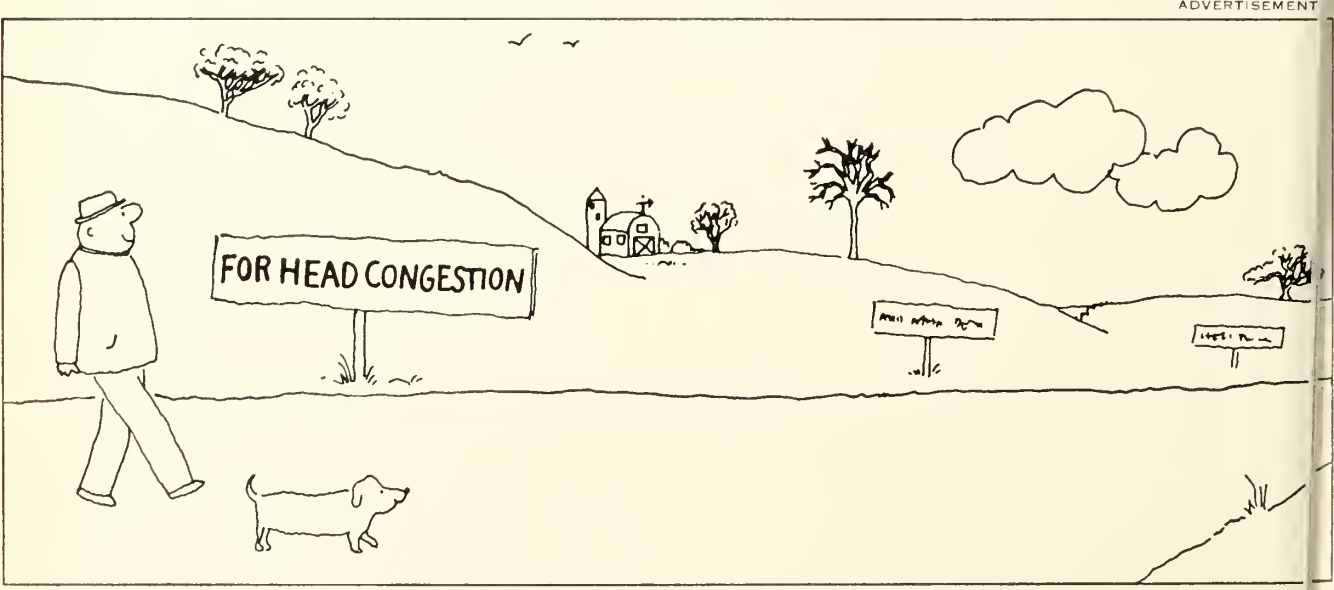
Query: This "composite average percentage increase" is undefined. If determined simply on the increase in individual allowances it seems of little use; the intent may be to weigh the increases by the relative frequency of the procedures to indicate the potential percentage increase in expenditures.

Guidelines are set up for HEW approval of an application, but approval is not mandatory on meeting these criteria.

During fiscal year 1970 (July 1, 1969-June 30, 1970), in addition to requirements in effect now, a revised payment structure *may* be approved if it includes not more than the 75th percentile of the range of customary charges in the state as of January 1, 1969. (No alternative date given.)

After June 30, 1970, revised payment structures *may* be approved if they include not more than the 75th percentile as of January 1, 1969 *plus* a "composite average percentage increase" (again undefined—see Query above) based either on the all-service Consumer Price Index (less the medical component) percentage increase or on an alternate index designated by HEW.

ADVERTISEMENT



To achieve this increase, the state will also have to show evidence of collaboration with the professionals concerned to establish an effective utilization and quality control system, including disqualification of practitioners found to have abused the program.

The regulations also require states applying for a revision at this time to make provision for prior authorization of selected services.

Query: Regulations do not indicate which services, on what basis selected, or by whom (HEW or state).

Even if it meets the above criteria, *no* revised payment structure can be approved if it results in payments exceeding reasonable charges under Medicare-B.

STATES WITHOUT PROGRAMS

The ten states which do not have Medicaid programs in effect July 1, 1969

(Alabama, Alaska, Arizona, Arkansas, Florida, Indiana, Mississippi, New Jersey, North Carolina, Tennessee)

will submit initial state plans with payment structures in compliance with the section listing HEW "guidelines" for approval of revised payment structures.

A plan *submitted during FY 1970* must meet general requirements for a state plan, plus a payment structure including not more than the 75th percentile of the range of customary charges in the state as of January 1, 1969.

A plan *submitted after June 30, 1970* may have a payment structure including not more than the 75th percentile plus the Consumer Price Index or alternate index percentage increase, a utilization and quality control system, and provision for prior authorization of selected services.

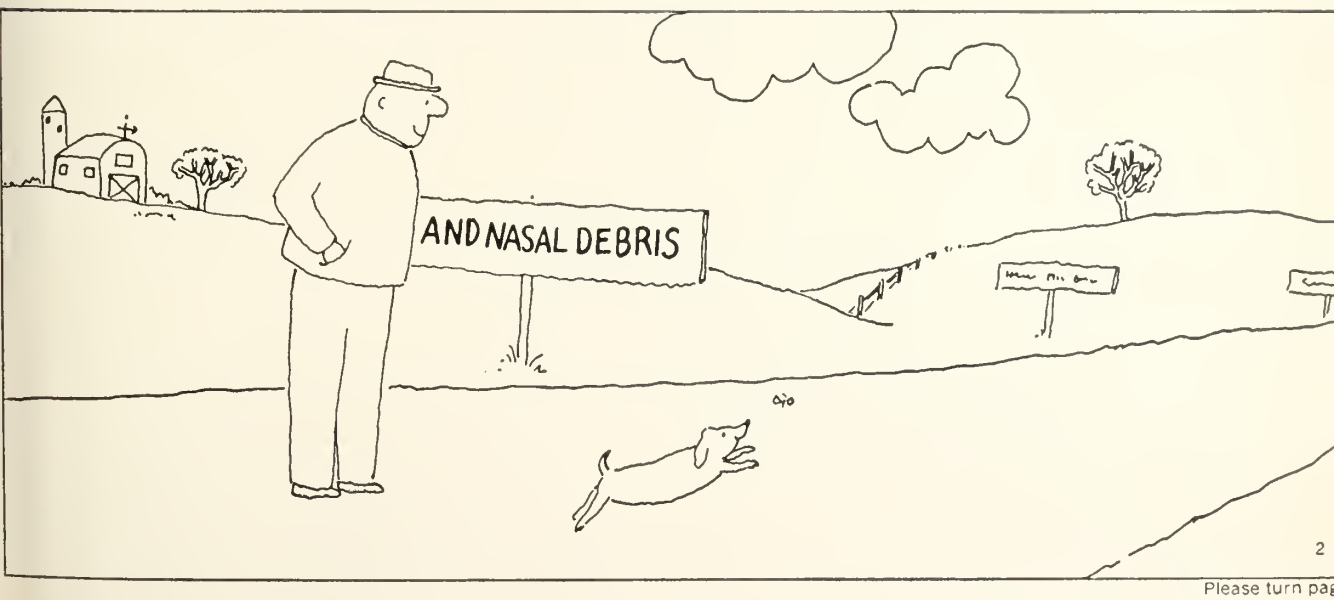
Query: Regulations do not indicate how a state whose program begins July 1, 1969 or later should determine the range of customary charges as of January 1, 1969. Apparently, this is at present left to state initiative.

REIMBURSEMENT—IMPACT

N. B.: The following is strictly a staff rough estimate from limited data available.

Of the 43 plans in effect before July 1, 1969, three (Guam, Puerto Rico, Virgin Islands) use primarily salaried physicians. This regulation should have little impact there.

Of the remaining 39 plans (38 states and the District of Columbia), staff compilation of



Please turn pag

existing data on June 12, 1969, indicated that 19 programs were paying physicians at a level equivalent to Medicare-B or below. Eleven of these states used the Medicare schedule, eight were significantly below the 75th percentile level. For the remaining 20 plans in effect the beginning of 1969, and Virginia (which began July 1, 1969), data is inadequate for any even partially accurate comparison of fee with the percentile range of customary charges.

However, if these data are roughly the same in the "unknown" states, it appears that in almost no states will this regulation cause any immediate *reduction* in payments to physicians.

In about half the states, however, no increase in the fee structure would be permitted until the Medicare-B current reasonable charge (say 83rd percentile) becomes equivalent to the January, 1969 75th percentile plus a CPI percentage increase—probable two years or more at present rates.

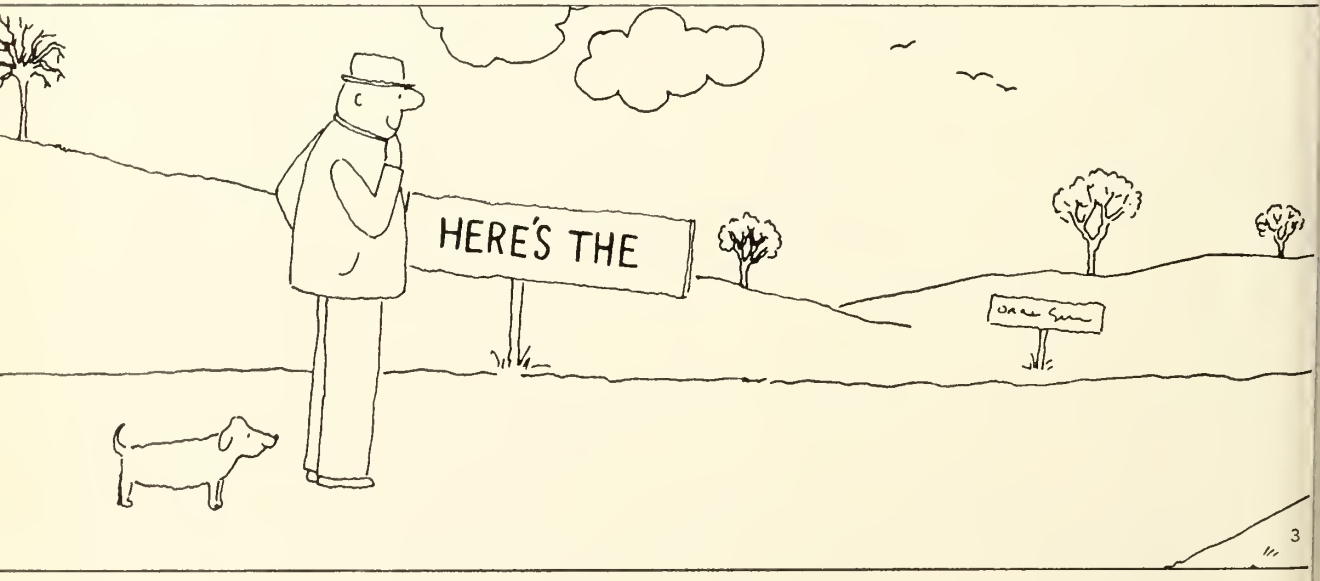
In a few states (probably three or four) which are now at the 75th percentile, the first increases would become possible during FY 1971, and then only for the CPI percentage increase (probable 5 percent).

In a little under half the states, which now pay less (sometimes significantly less) than the 75th percentile, immediate fee increases are possible, without regard to the CPI.

All such changes, however, will be subject to state decision to request and HEW decision to approve; no increase to the ceilings set in the regulations are automatic. Clearly, both the states and HEW will be reluctant to permit such increases.

All changes will also require that states develop a customary charge profile for each participating physician and a range of customary charges for the state, including variations in the range of customary charges for different areas within the state and for different specialties. They will also require that states develop different payment structures for institution-based physicians and for nursing-home visits, and for such other special instances as the state or HEW may decide require variations in the payment structure.

Every state, whether or not it seeks change, must incorporate in its state plan, on file in Washington, either a maximum schedule of allowances (for UCR plans, listing the most frequent procedures) or a fee schedule (for fixed fee plans) or an identified RVS and conversion factor. Under present freedom of information laws, these *may* be open to public inspection.



After June 30, 1970, *no* change in the fee structure will be possible unless the state has, with the professionals concerned, *set up utilization and quality controls, with penalties,* and has provision for prior authorization for selected services.

CONCLUSION

The *immediate* impact on payment to physicians will be slight. During the next year perhaps a little under half the states could increase fees somewhat. After June 30, 1970, however, increases will require an effective utilization and quality control system and detailed data on customary charges for most of the nation's physicians.

"Blemishes on the Map of Paradise" might be the caption on an account of how the high incidence of respiratory disorders on Oahu is traced to the use of insect sprays. Because Hawaii has a mild climate the year around, it needs more than twice as much insecticide as any other State of the Union. The results are physically unhappy.

* * *

"All Drugs Are Not Created Equal," is the caption on a recent Medical World News article urging that generic drugs be put to the test of therapeutic effectiveness.

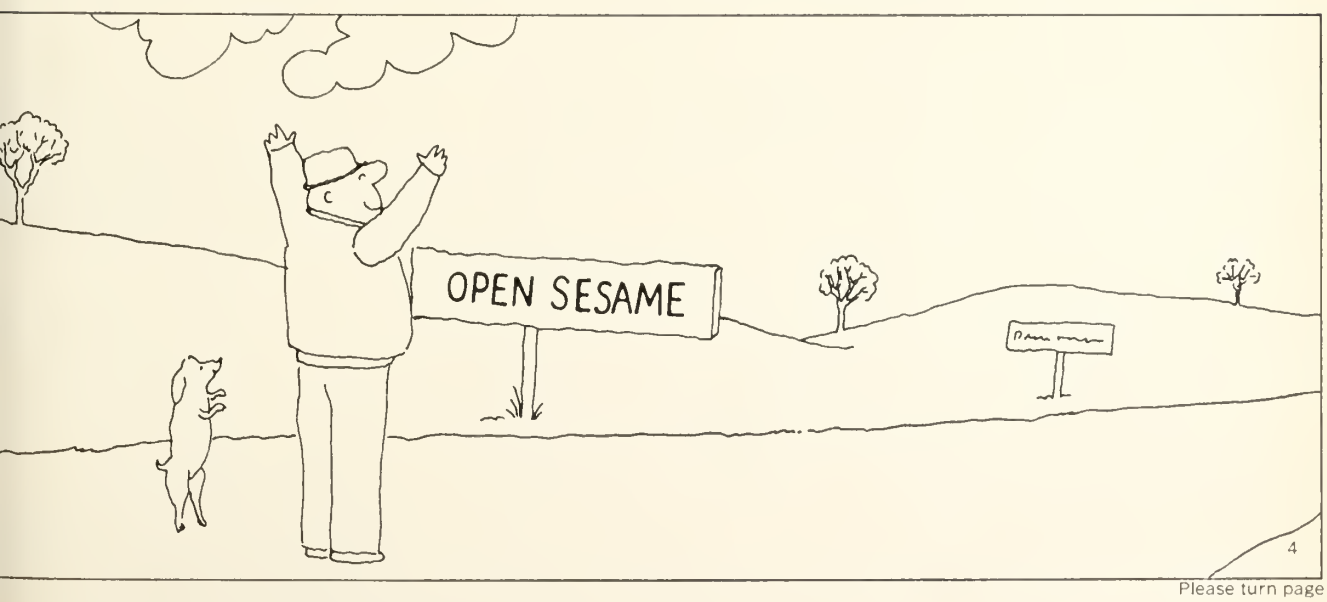
For Want Of Communication

Arthur V. Dudley, Jr., M. D., who retired last April as president of the Arizona Medical Association, stressed in his valedictory the effort he had made to "communicate" in the 12 months of his administration.

He mentioned such comments as: "We members don't know what the Association is doing" and "What are our dues being spent for?" and "Organized medicine doesn't speak for me." Then he added: "As a new member of ArMA I was as guilty of this as others are now. However, I did attend county society meetings and have been in regular attendance at State Association meetings for the past 15 years."

During his administration and in those following, he said: ". . . your Association will attempt to keep you informed on current events in the Legislature and will be better able to call on individual doctors to appear before Legislative Committees to speak for organized medicine. Just another way we hope to improve communications.

"The ultimate solution is live TV, but that is truly in the dim future."



Please turn page

Percentile Payment Formulas as Used In Medicare and Medicaid

The use of percentiles in establishing ceilings on physician reimbursement has been explained as follows:

The percentile is not a measure of quantity, but of rank in a series. The xth percentile includes, not x per cent of any amount, but x per cent of the items in an ordered series.

In the regular series of one hundred numbers from 1 to 100, the 70th percentile will be number 70—including 70 per cent of the numbers in the series. In the regular series of even numbers from 2 to 200, the 70th percentile will be 140, again including 70 per cent of the numbers in the series.

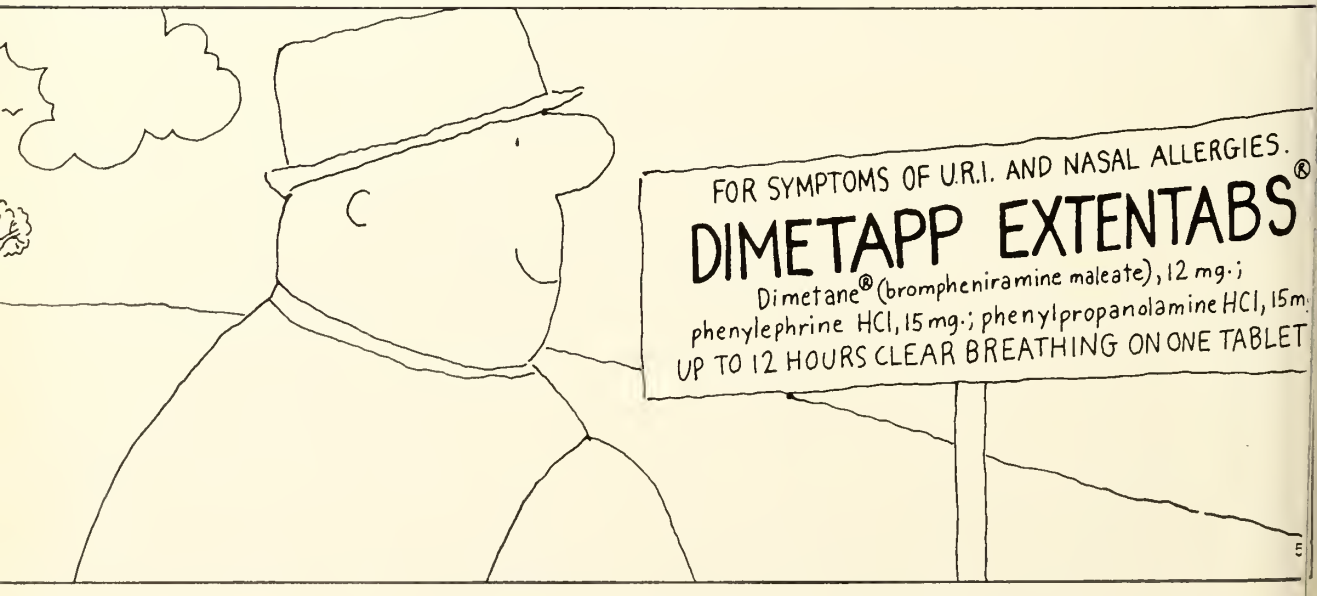
In a random series of ten ascending numbers (e.g. 3- 7- 8- 12- 19- 20- 21- 24- 30- 32) the seventh number (in this case 21) will be the 70th percentile. In a repeating series of ten numbers—say 2, 2, 2, 5, 5, 5, 7, 7, 10, 10—the 70th percentile will be 7, again including 70 per cent of the numbers in the series.

PERCENTILE IN PAYMENT FORMULAS

As used in Medicare and Medicaid, the percentile simply indicates where, in a series of charges for a service, ranged from low to high, the ceiling on payment is placed. It does *not* represent a percentage of the individual physician's fee, and bears no necessary relation to the total billing.

Example: For a certain procedure, the usual charges of ten physicians are: $10, $12, $12, $14, $16, $8, $10, $10, $12, $14. In order from low to high, these charges are: $8, $10, $10, $10, $12, $12, $12, $14, $14, $16. If the ceiling on payment for the procedure is set at the 70th percentile of these usual charges, the maximum payment would be $12, the seventh in the series of ten. Physicians in this group billing $12 or less would receive their full fees, whether $8, $10, or $12; physicians billing $14 or $16 would receive only $12.

The above example indicates some of the



characteristics of percentile fee ceilings which have caused confusion for those unfamiliar with statistical methods.

In this series, the 70th percentile is $12—but so is the 60th percentile and 50th percentile. In this particular series of charges, the ceiling is the same whichever of these three percentiles is chosen. Similarly, the 80th and 90th percentiles in this series are identical; if the ceiling were set at the 80th percentile, it would actually permit full payment of nine of the ten charges listed.

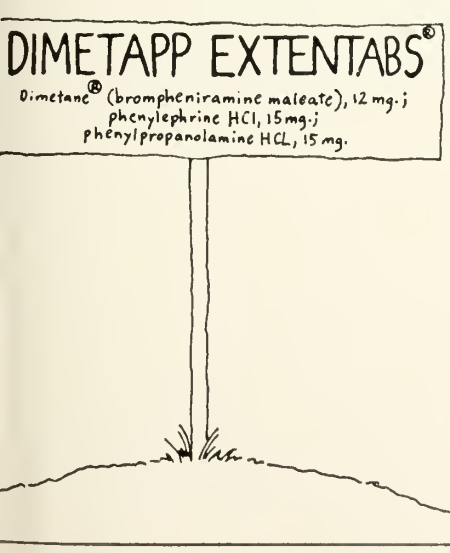
(N. B. This is an arbitrarily chosen imaginary series of charges. This particular distribution—the identity of the 20th-30th-40th, the 50th-60th-70th, and the 80th-90th percentiles—does not necessarily apply to any real series of charges. However, the tendency of professional charges for a given procedure to "bunch" at certain levels does often result in only slight variations between two distinct percentile levels.)

Further, the ten charges listed total $118. Using the 70th percentile ($12) as the ceiling, the $8 charge, the three $10 charges, and the three $12 charges would be paid in full, while $12 would be paid for each of the two $14 charges and the $16 charge, for a total of $110 or 93.2% paid of the total $118 billed. It is often possible for the per cent of total billings paid to exceed significantly the percentile at which the ceiling is set.

Neither, clearly, does the percentile directly indicate what percentage of the individual bill is met. In the above series, those charging $8, $10, or $12 receive 100 per cent of their fee with a 70th percentile cut-off; those charging $14 will receive 85.7 per cent, and those charging $16 will receive 75 per cent of the amount billed.

NEW MEDICAID REIMBURSEMENT FORMULA

The July 1, 1969 regulation establishes the eventual ceiling on Medicaid reimbursement at the 75th percentile of the range of customary charges which existed on Jan. 1, 1969. After June 30, 1970, these ceilings would be permitted to rise in relation to increases in HEW selected segments of the Consumers Price Index (CPI). The table on the following page illustrates an application.



INDICATIONS: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, hayfever and conjunctivitis.

CONTRAINDICATIONS: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.

PRECAUTIONS: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

SIDE EFFECTS: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.

DOSAGE: 1 Extentab morning and evening.

SUPPLIED: Bottles of 100 and 500.

A·H·ROBINS A. H. ROBINS COMPANY RICHMOND, VIRGINIA 23220

6

(Continued from Page 261)

The following has been developed as an example of how this would work: In a group of twenty physicians, the customary charges for four procedures (A, B, C, D) are as follows:

PROCEDURE A: 6 charge $4.00, 9 charge $5.00, 3 charge $6.00, 2 charge $6.50

PROCEDURE B: 6 charge $90.00, 10 charge $100.00, 2 charge $125.00, 2 charge $140.00

PROCEDURE C: 2 charge $10.00, 14 charge $12.00, 4 charge $15.00

PROCEDURE D: 4 charge $40.00, 4 charge $45.00, 10 charge $50.00, 2 charge $55.00

	Number of physicians																				75th percentile	Total Billed	Paid	% Paid
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	75th pctl.			
A	$4.00						$5.00									$6.00			$6.50		$ 5	$ 100	$ 94	94
B	$90.00						$100.00										$125.00		$140.00		100	2070	1940	94
C	$10.00						$12.00											$15.00			12	248	236	95
D	$40.00				$45.00					$50.00									$55.00		50	950	940	99

Note: In most cases, it is probable that the *percentage of the total billing* PAID will exceed the 75th percentile. If the 25 per cent of physicians above the ceiling all charged twice as much as the ceiling, and the rest charged the ceiling, 80 per cent of the total billing would be paid. If 25 per cent charged half the ceiling, 50 per cent the ceiling, and 25 per cent twice the ceiling, 77 per cent of the total would be paid. Even if 40 per cent charged half the ceiling, 35 per cent at the ceiling, and 25 per cent twice the ceiling, 76 per cent of the billing would be paid. The fact that only 25 per cent of the physicians have their bills discounted, while all others are paid in full, tends to raise the percentage of total billings paid above the 75 per cent mark.

From A Symposium on Psychosomatic Medicine

Stewart Wolf, M. D., Oklahoma City:

The creation of societies required that males learn to live together without destroying each other; now, the survival of society requires that we learn to tolerate differences in people and their points of view. The stress-fraught adaptations . . . provide much of what is noxious in the environment of modern man.

Mark D. Altschule, M. D., Boston:

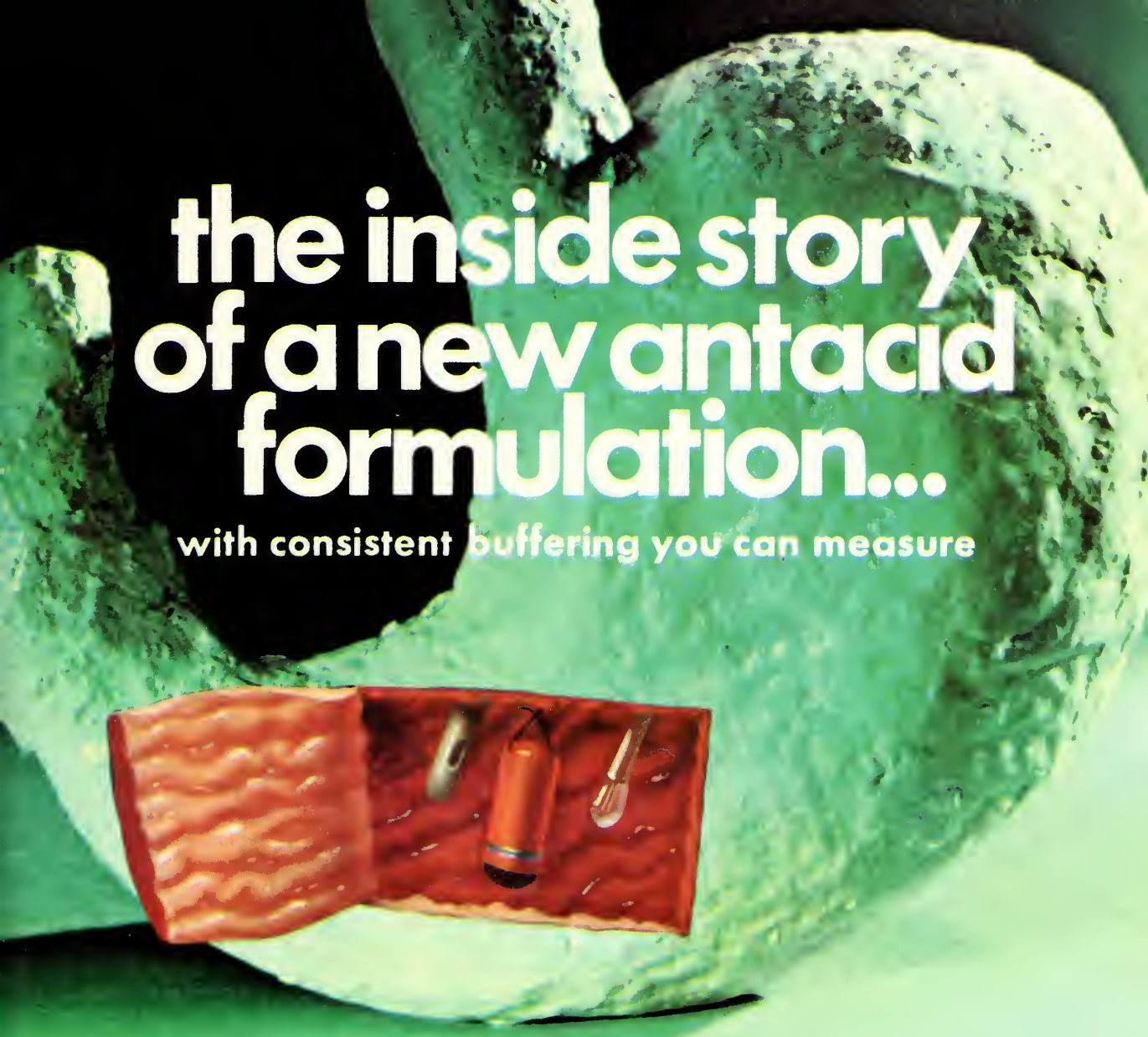
Emotion itself causes gastric hypermotility directly. With regard to acid secretion during emotional stress, in normal persons it has been reported increased or decreased; in ulcer patients the data show no change or an increase.

Robert N. Butler, M. D., Washington, D. C.:

There will not come a day when there will not be psychologic problems for the aged, but the opportunity to help resolve them does partly depend upon society's willingness for the older person to remain contributory and participatory in the mainstream of society and upon society's commitment to fully support the socioeconomic needs of the elderly.

Richard K. Kertel, M. D., Ann Arbor, and John P. Kemph, M. D., Brooklyn:

From an uneasy beginning, some patients (in kidney transplantation) move successfully back into life for their few years of borrowed time, while others huddle in the shadow of their hospital experience, physically capable of more, but feeling too vulnerable to attempt it.



the inside story of a new antacid formulation...

with consistent buffering you can measure

consistently scored high in degree and duration of intragastric buffering

Employing aspiration of gastric juice, indwelling electrode, and/or Heidelberg telemetering capsule techniques,* studies involving 79 subjects with or without proven peptic ulcer disease compared intragastric buffering capacity of Gelusil-M and 1 or the other or both of 2 leading ethical antacids, using comparable doses.*

All three antacids raised the pH above 3.5, an accepted criterion for antacids. The amount of time above this pH helps to characterize the buffering activity of an antacid. While it is not implied that a direct therapeutic correlation exists, these techniques do, however, objectively demonstrate the buffering characteristics of this new antacid in terms of onset of action, peak pH, duration of buffering action.

Mean peak pH*

Gelusil-M, mean peak pH 6.6 (range: 5.6-7.8).
Antacid A, mean peak pH 5.5 (range: 4.2-7.5).
Antacid B, mean peak pH 5.5 (range: 4.4-6.3).

Mean duration of buffering action above pH 3.5*

Gelusil-M, 29.8 mean minutes (range: 18.0-51.8 minutes).
Antacid A, 24.6 mean minutes (range: 6.3-48.0 minutes).
Antacid B, 23.3 mean minutes (range: 5.9-50.0 minutes).

Mean duration of buffering action above pH 5.0*

Gelusil-M, 23.2 mean minutes (range: 14.3-43.9 minutes).
Antacid A, 10.1 mean minutes (range: 6.7-12.2 minutes).
Antacid B, 16.3 mean minutes (range: 8.0-24.2 minutes).

Onset of action*

In speed of intragastric buffering action, Gelusil-M, Antacid A, and Antacid B were consistently rapid and not measurably different.

*References: Antacid studies, data on file, Worner-Chilcott Laboratories Division.

introducing new

GELUSIL®-M

each 5 ml. teospaanful contoins:
500 mg. magnesium trisilicate, 250 mg. aluminum hydroxide
(Worner-Chilcott), 200 mg. magnesium hydroxide
U.S. Potent No. 3,326,755

a consistent buffering anticostive† antacid

† Avoids constipation.

See next page far prescribing infarmatian ►

GELUSIL–one name to remember...and a dosage form for every patient.



Gelusil®-M Liquid

especially for the constipation-prone patient

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

a universal take-along antacid

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquid

when constipation is not a problem

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)—or more—between meals and at bedtime, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey

GM-IN-93-4C

(Continued from Page 203)

dren in the United States. If at that time all child services are provided by pediatricians and the availability of pediatricians per unit of child population is the same as in 1961 (151 for 100,000), then about 115 thousand pediatricians will be needed to practice in the year 1980 as compared with 15,000 in practice at the present date. This is an increase of 100,000 pediatricians in 11 years, approximately the estimated number of total medical graduates in that period. The present rate of pediatric production is 1,000 per year. How then may this man-power demand be met?

There are estimates that 25 per cent to 40 per cent of the work now done by certain physicians could be performed by paramedical personnel. The military services have used trained civilian corpsmen to perform skilled medical duties for years and familiar examples of medical assistance in general hospitals are physical and occupational therapists, "airway teams," operating room nurses, etc. In many hospitals nurses are performing procedures such as IV infusions and ultimately may be trained to do more technical procedures such as spinal punctures, bone marrow aspirations, etc. Duke University Medical School for some years now has been training people below the graduate level to become assistants in the various branches of medicine.

The University of Colorado Pediatric Nurse-Practitioner program is receiving national attention. This program endeavors to prepare nurses to assume an expanding role in providing total health care to children in offices of private practitioners and in areas of inadequate health services. Nurses are trained to provide comprehensive well child care and to appraise and temporarily manage certain acute and chronic conditions of the sick child. This program was developed jointly by the Department of Pediatrics of the School of Medicine and School of Nursing of University of Colorado. Nurses receive approximately four months of intensive theory and practice in pediatrics at the medical center where they have assignments on wards and in clinics. They learn interviewing techniques and the basic skills involved in physical examination, including inspection, palpation, percussion and oscultation, as well as the use of the otoscope, etc. They get some training in parent-child relationships, growth patterns, physical and psychological development, infant nutrition, immunization procedures, counseling, etc. They participate in the care of well children and in the management of those with a variety of acute and chronic illnesses, including upper respiratory infections, otitis media, various skin eruptions, diarrhea, constipation, allergic manifestations and common contagious diseases. They evaluate hearing defects, speech difficulties, visual impairment and have some knowledge of the essentials of good dental care, and the identification of dental problems. They also learn certain simple laboratory procedures such as urinalysis, hemoglobin determination and etc. They are taught to give emergency assistance to accident and poison victims.

After her four months training period at the medical center the pediatric nurse-practitioner functions in the office of a pediatrician in private practice or in a field station in a low income urban or rural area where she is readily accessible to people. She always functions under the supervision and direction of a physician, although he may not be physically present at all times. The pediatric nurse-practitioner is said to be able to give total care to more than 75 per cent of the children who come to the field station, including almost all the problems of well children and approximately half of those of the ill ones. In the office of the private pediatrician she performs essentially the same functions as in the field station.

From the experience gained so far the people involved believe that competent nurses working cooperatively with physicians can increase the contribution they both

(Continued on Page 267)

The AMBAR® SCRAPBOOK of

Obesity Oddities

FACT & LEGEND

OBESITY WAS A MILITARY OFFENSE!

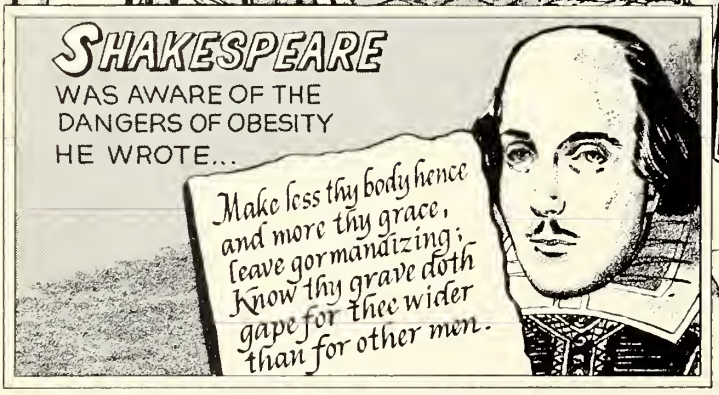
OVERWEIGHT ROMAN HORSEMEN WERE MADE TO FORFEIT THEIR MOUNTS AND BECOME FOOT SOLDIERS!

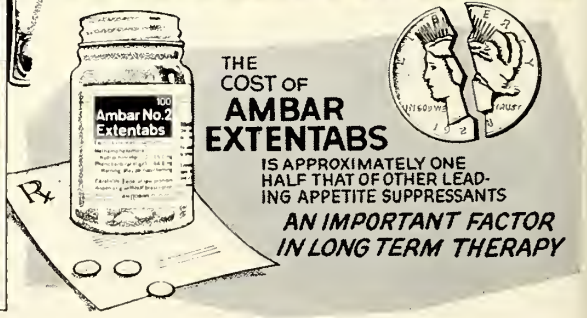


RECORDED ON AN ENGLISHMAN'S TOMBSTONE

SHAKESPEARE

WAS AWARE OF THE DANGERS OF OBESITY HE WROTE...





THE COST OF **AMBAR EXTENTABS** IS APPROXIMATELY ONE HALF THAT OF OTHER LEADING APPETITE SUPPRESSANTS

AN IMPORTANT FACTOR IN LONG TERM THERAPY

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS

(Continued from Page 265)

make to overall patient care and that this program provides one way that physicians' assistants may be developed so that comprehensive patient care may be provided to meet the expanding need.

In California, since 1964, nurses have been operating child health conferences under the supervision of, but without the presence of, pediatricians. Similar neighborhood primary health centers have been established in New York, Boston, Chicago, Philadelphia, Los Angeles, Palo Alto and Mound Bayou, Mississippi.

Recently the American Academy of Pediatrics has given much thought to the training of pediatric assistants. The feasibility and acceptability of the utilization of auxiliary personnel in pediatrics was dramatically demonstrated by a special presentation by the Council on Pediatric Practice of the American Academy of Pediatrics in Chicago in November, 1968. The Sub-Committee on Pediatric Man-power presented results of a survey of possible allied health worker utilization in pediatric practice. Almost 90 per cent of board certified pediatric practitioners responded to the survey. The majority indicated they would hire an allied health worker on full-time or part-time basis to discharge many patient care tasks if such workers were available. The survey indicated that pediatricians felt that from 25 per cent to 50 per cent of their time could be freed by properly trained assistants.

In June, 1969 the American Academy of Pediatrics Executive Board approved the establishment within the Academy's Central Office of a Division of Allied Child Health Man-power. The present official position of the Academy is that a physician may delegate to a properly trained individual working under his supervision the responsibility of providing appropriate portions of health examinations and health care for infants and children. The director of this Division of Allied Child Health Man-power will establish objectives, develop long-time goals and create operational policies. Planning and specific objectives are now being studied.

At the University of Alabama in Birmingham the School of Health Services Administration is developing a Regional Technical Institute for Health Occupations. Funding in the amount of $952,000 for a building has recently been granted by the Appalachian Commission. Added state funds make a total project of 1.19 million dollars. Building is scheduled to be completed in January, 1970. When fully operational the school's estimated enrollment will be 500 students annually. Training will be on a post-high school, subbaccalaureate level. Objects of the Regional Technical Institute are " to provide a source of man-power to help meet immediate needs in hospitals and related health-care institutions throughout the state of Alabama—, to serve as a demonstration educational center for the state—, and to be innovative in curriculum development, delivery techniques, and audio-visual technology." This institute "will have the complete support of other academic and service units of the University of Alabama in Birmingham."

Although limited by space, equipment and operational funds, the Regional Technical Institute is already training people in the following categories:

Anesthesia for Nurses

Certified Laboratory Assistant

Cytotechnology Technician

Histologic Technician

Pathologist Assistant

Radiologic Technician

Electroencephalograph Technician

Additional programs to be developed when the building is completed include:

Ambulance Attendant

Bio-Medical Engineering Equipment Repair

(Continued on Page 270)

Symbols in a life of psychic tension

M.A.

class of '66

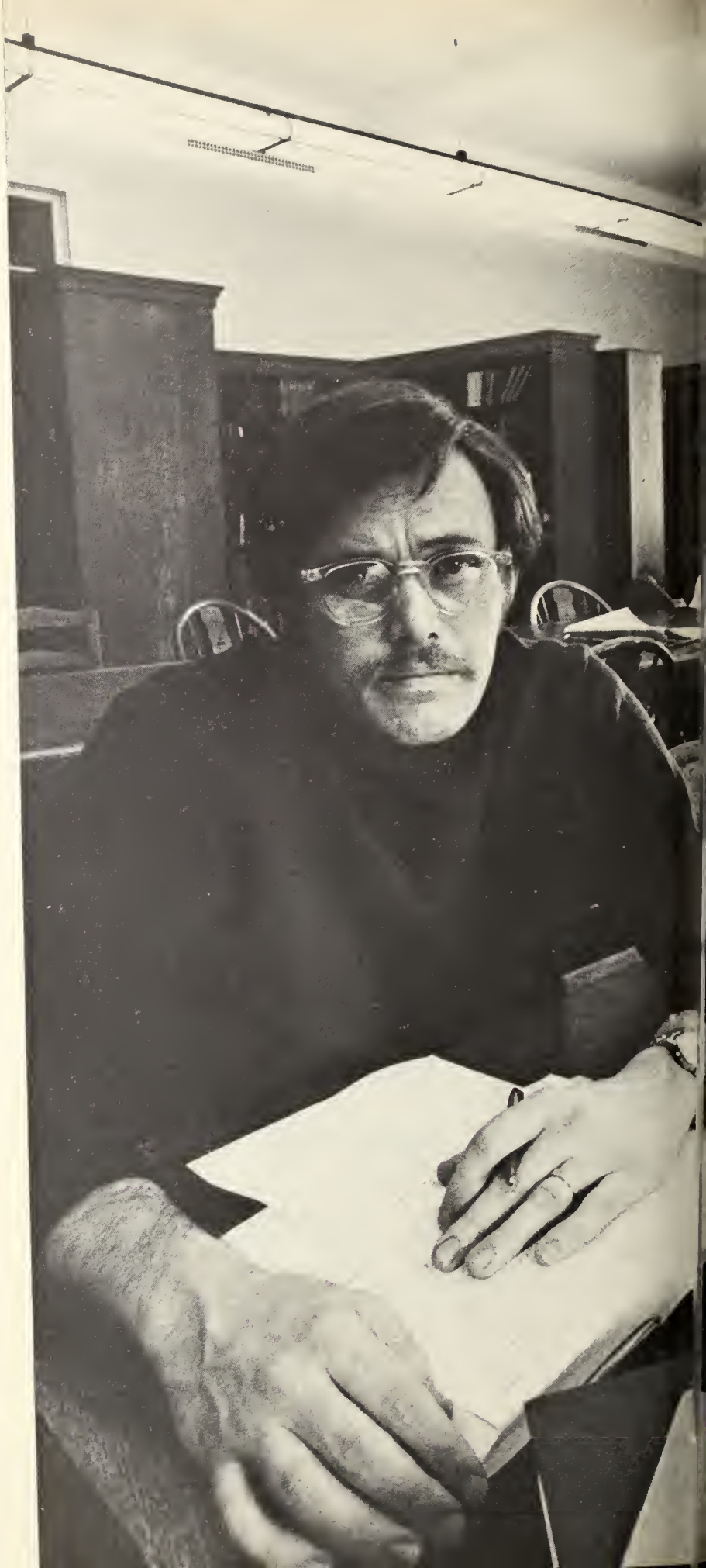
Ph.D.

thesis...in progress

G.I.

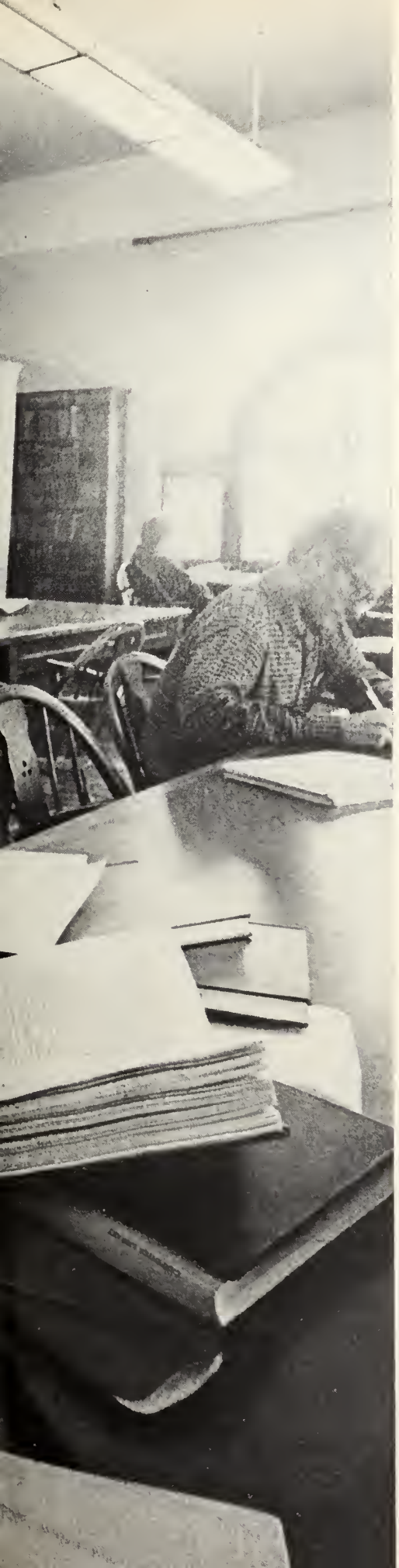
series and complete examination normal

(persistent indigestion)



ROCHE

Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Rx

Valium® (diazepam) *t.i.d.* and *h.s.*

M. A. (class of '66)... Ph.D. (thesis, in progress)... letters that represent a young lifetime of work... a formal education nearing completion. But there are still long, arduous examinations to pass, a doctoral thesis to finish... a period in which stress is often converted into the gastrointestinal symptoms of psychic tension. For this kind of patient—with no demonstrable pathology—consider the usefulness of Valium (diazepam).

Valium can help relieve psychic tension and resultant somatic symptoms, within the first day for some patients. Valium is also useful in psychic tension with associated depressive symptoms. And Valium can help relieve psychic tension-induced insomnia with an *h.s.* dose added to the *t.i.d.* schedule.

Valium is generally well tolerated. In proper maintenance dosage it seldom dulls the senses or interferes with functioning. Side effects most commonly reported have been drowsiness, fatigue and ataxia.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

to help relieve psychic tension
and its somatic symptoms

(Continued from Page 267)

Dental Assistant

Dental Laboratory Technician

Dietetic Supervisor

Dietetic Technician

Inhalation Therapist

Isotope Technician

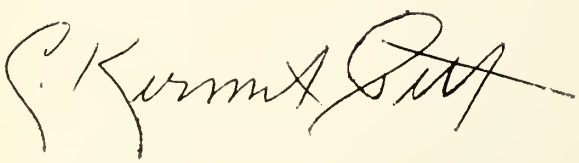
Medical Data Processing

Occupational Therapy Assistant

Surgeons' Assistant

The probability of including Pediatric Assistant trainees is being studied.

This brief review indicates some radical departures from our past system of delivering health care and confirms the fact that the winds of change blow hard upon us. We must not become infatuated with change for change sake, but must be willing to examine our long-held notions and meet the challenges in medicine as well as those in all the other phases of our lives. We must increase our involvement in the development of health care patterns, so that we may give direction to the promotion of a system involving educational institutions, private medicine and governmental agencies working together, in harmony with the principles of free enterprise, which will provide the best medical care for all people everywhere. This accomplishment, if it is to be attained, will not be without errors and frustrations. Vision and fortitude will be required.



C. Kermit Pitt, M. D.

BOOKS

Of Professional Interest

CANCER WARD. By Alexander Solzhenitsyn. Farrar, Straus & Giroux. 560 pages, including appendices of documents relating to the suppression of the book in the Soviet Union. $10.

Cancer Ward is a novel about Russia and by a Russian. The book has not been published in Russia, however, and it does not take the reader long to discover why. The book is a savage attack and exposure of a system in which human beings are looked upon as cogs in a machine. But only the most shallow-minded reader would see the book as merely an expose. Rather, it is one of those rare works of fiction—so infrequently seen in America today—which deals, as Faulkner put it, "in the problems of the human heart in conflict with itself."

Cancer Ward is set in the mid-1950's in an obscure, unnamed village somewhere in the far reaches of Soviet Asia, just at that point when Russia is about to emerge from the Stalinist nightmare and enter that period that is now known as "the Thaw." The scene is a cancer ward of a state hospital, and the characters represent all the various components of Russian society. Brought together as clashing and uncongenial elements, they all share certain things in common: each is a victim of Stalinist terror, in one way or another, and each faces the prospect of great suffering and imminent death—a condition which brings out the honesty in men.

There is Kostoglotov, who has spent his relatively short life either as a conscripted soldier or as an exile in the notorious prison camps. His crime was that of thinking for himself at a time when the state demanded to do all the thinking for the people. Yet he has somehow emerged with his spirit unbroken, still capable of pity and compassion for a little monkey in the town zoo which has been blinded by a spectator, simply for the joy of hurting a defenseless creature.

(Continued on Page 275)

Can one prescription do the work of two?



Yes, Kolantyl®.

Kolantyl Gel/Wafers contain antacids, and Bentyl® (dicyclomine hydrochloride) too.

Merrell

The Wm. S. Merrell Company
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215

WHAT'S SO WEAK ABOUT THE WEAKER SEX?

OFTEN... HER LOWER G.I. TRACT



Psycho-abdominal Distress: Frequently Female

Women aged 15 to 45 appear to be more prone than men to bloating, cramping pain of stress-related intestinal disturbances such as irritable or spastic colon.[1,2]

Frequently Recurrent

In the experience of many physicians, women are more likely to reappear time after time with repeated complaints of lower G.I. distress.

Requiring Definitive Therapy

Often needed is therapy adequate to control both the somatic and the emotional components of psycho-abdominal complaints.

Definitive Dual Therapy

'Milpath' contains a proven synthetic anticholinergic useful for relieving hypermotility, spasm, and hypersecretion of the gastrointestinal tract.

In addition, 'Milpath' provides a time-tested tranquilizer for mild but effective anti-anxiety action.

With Flexible Dosage

- 'Milpath'-400 (meprobamate 400 mg. + tridihexethyl chloride 25 mg.) Usual adult dose: 1 tablet *t.i.d.* and 2 at bedtime.
- **When less tranquilization is required: 'Milpath'-200 (meprobamate 200 mg. + tridihexethyl chloride 25 mg.)**

Wallace Pharmaceuticals/ Cranbury, N. J. 08512

gently but firmly

MILPATH®

(meprobamate + tridihexethyl chloride)

relaxes smooth muscle and psyche

Please see the following page for brief summary of prescribing information.

Gently but firmly MILPATH®

(meprobamate + tridihexethyl chloride)

Relaxes smooth muscle and psyche



Usual Adult Dosage

One 'Milpath'-400 tablet, three times a day at mealtimes, and two at bedtime. For greater anticholinergic effect, two 'Milpath'-200 tablets, three times a day at mealtimes and two at bedtime. Doses of meprobamate above 2400 mg. daily not recommended.

Indications

Useful in organic and functional disorders with hypersecretion and hypermotility of G.I. tract, especially when accompanied by anxiety, neurosis, or tension states. Should be used as an adjunct to all other therapeutic measures.

Contraindications

Tridihexethyl chloride: Urinary bladder-neck obstructions, e.g., prostatic obstruction due to hypertrophy; pyloric obstructions because of reduced motility and tonus: organic cardiospasm (megaesophagus); glaucoma; possibly in stenosing gastric or duodenal ulcers with significant gastric retention.

Meprobamate: Previous allergic or idiosyncratic reactions to meprobamate.

Precautions

Tridihexethyl chloride: Use cautiously in elderly males (possible prostatic hypertrophy).

Meprobamate: Carefully supervise dose and amounts prescribed. Consider possible dependence or habituation (reported occasionally after excessive use), particularly in severe psychoneurotics, alcoholics, ex-addicts. Withdraw gradually (one or two weeks) after excessive dosage for weeks or months to avoid recurrence of pre-existing symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching; rarely, epileptiform seizures, more likely in those with CNS damage or latent convulsive disorders). If drowsiness or visual disturbance occurs, reduce dose and advise against activity requiring alertness (driving, machinery operation). Effects of excess alcohol may be increased. Grand mal seizures possible in persons with both petit and grand mal. Prescribe cautiously in small amounts to patients with suicidal tendencies. Prescribe with caution to patients with known sensitivity to compounds of similar chemical structure, e.g., carisoprodol.

Side Effects

The following side effects of components may occur with 'Milpath'.

Tridihexethyl chloride: Severe effects rare on recommended dosage. Anticholinergic effects: dry mouth (fairly frequent at oral doses of 100 mg.), constipation or "bloated" feeling. Possible: tachycardia, dilation of pupils, increased ocular tension, weakness, nausea, vomiting, headache, drowsiness, urinary hesitancy or retention, dizziness.

Meprobamate: Drowsiness, sometimes with ataxia, usually controlled by decreasing dosage, occasionally with aid of central stimulants (e.g., amphetamine). Rarely, allergic or idiosyncratic reactions (usually after one to four doses); in mild form: itchy, urticarial or erythematous, maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever, transient leukopenia, and one fatal bullous dermatitis (after meprobamate and prednisolone) reported. More severe, very rare hypersensitivity: fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (one fatal), anuria, anaphylaxis, stomatitis and proctitis. Treat symptomatically (e.g., epinephrine, antihistamines, possibly hydrocortisone); stop and do not restart the drug. Isolated agranulocytosis, thrombocytopenic purpura, one fatal aplastic anemia reported, but only in presence of known toxic drugs, porphyric symptoms reported but relationship not established. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation reported by one observer. Fixed drug eruption with meprobamate and cross reaction to carisoprodol reported.

Suicidal attempts may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Excessive dosage has led rapidly to sleep, then reduction of vital signs to basal levels. Empty stomach, and if respiration becomes very shallow and slow, cautiously give CNS stimulants (e.g., caffeine, pentylenetetrazol, amphetamine); also pressor amines if indicated.

Supplied

In two strengths:
'Milpath'-400: Yellow, scored tablets.
'Milpath'-200: Yellow, coated tablets.
Before prescribing, consult package circular.

References

1. Harrison, T. R., et al.: Principles of Internal Medicine, Fifth Edition, New York, The Blakiston Division, McGraw-Hill Book Company, 1966, p. 1019. 2. Bockus, H. L.: Gastroenterology, Second Edition, Philadelphia & London, W. B. Saunders Company, 1964, Vol. II, p. 729 et seq.

(1928A01J)

(Continued from Page 270)

There is Shulubin, the aged intellectual who capitulated to every outrageous demand in his desperate quest for survival. He lied, he burned books, he turned his back on friend and neighbor. But he has reached the end of his life with the certain knowledge that while he has saved his skin, he has lost his soul. "You haven't had to do much lying, do you understand?" he tells the prisoner Kostoglotov. "At least you haven't had to stoop so low—you should appreciate that! . . . My whole life I've lived in fear, but now I'd change places with you."

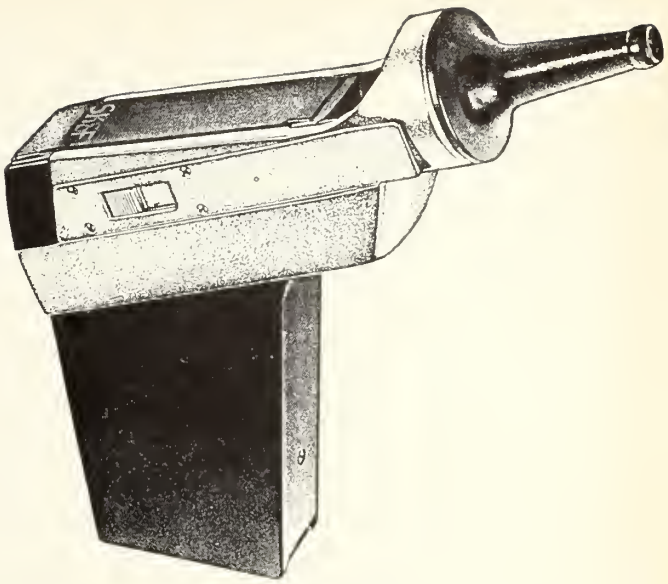
There is Vadim, the brilliant young scientist who somehow failed to learn in all his studies that life is to be lived and not to be prepared for.

And by contrast there is Dyomka, the credulous country boy who keeps hearing the uncertain voice within him, disputing and questioning dogmatic ideology, ever clinging to the vague notion that salvation comes from within and is not a gift of "the system."

There is Rusanov, the conscienceless, despicable, utterly loathesome bureaucrat who struggled up to the top by learning the techniques of putting secret, false information into the hands of the right people, who sent his friends and neighbors into exile. Rusanov, who loved "the People, the great People," but who found himself "less and less able to tolerate actual human beings, those obstinate creatures who were always resistant, refusing to do what they were told and, besides, demanding something for themselves." Rusanov, who now lies cancer-stricken, feeling not remorse but the simple fear that some of his victims will be released from prison and come back to beat him up. (No one can read the chapter on Rusanov's techniques without the realization that a few names could be changed, and we would have the account of the McCarthy period in this country.)

There is Gangart, the beautiful, thirtyish doctor who has claimed for herself the right

(Continued on Page 277)



See more, do more with the new Hotchkiss™ Otoscope

A revolutionary new instrument rather than an improvement over existing equipment, the Hotchkiss Otoscope employs the principles of modern optics to give you a brighter, clearer, more informative view of the ear canal and tympanic membrane. It's also more versatile than ordinary otoscopes—you can use it for diagnostic or operative procedures without making any changes. Yet the five-ounce Hotchkiss is lighter, easier to handle and carry, and every bit as durable as instruments that offer you less.

See for yourself. Clip and mail the coupon, and our Representative will call for an appointment to show you the new Hotchkiss Otoscope in your office.

SK&F Smith Kline & French Laboratories

Smith Kline & French Laboratories E-30 B
1500 Spring Garden Street
Philadelphia, Pa. 19101

I would like your Representative to call for an appointment to show me the new Hotchkiss Otoscope.

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Norflex®
(orphenadrine citrate, 100 mg.)

Takes the agony out of low back pain



Take the agony out of low back pain... Norflex® (orphenadrine citrate) relaxes the muscles in spasm.

Restore mobility and hasten recovery... prescribe Norflex 1 tablet b.i.d.

Indications: Acute spasm of voluntary muscles, regardless of location; especially post-traumatic, discogenic, and tension spasms. **Contraindications:** Due to its anticholinergic action, NORFLEX should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcer, prostatic hypertrophy or obstruction at the bladder neck, cardiospasm (megaesophagus) and myasthenia gravis. Use with caution in patients with tachycardia. Do not use propoxyphene (Darvon®) concurrently. **Adverse Reactions:** Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Adverse reactions are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported. **Dosage and Administration:** Two tablets per day for adults, regardless of weight or sex; one in the morning and one in the evening. Each tablet contains 100 mg. orphenadrine citrate.
For full information, see Package Insert or P.D.R.

Norflex®
(orphenadrine citrate)

Riker Laboratories
Div. of Dart Industries Inc.
Northridge, California 91324

The Riker representatives in your area are:
Robert Johnston
Billy J. Phillips
William O. Crabb
Paul E. Loeffler III

(Continued from Page 275)

to treat and has squared that claim with her conscience even though she is profoundly altering the lives of others without their knowledge or consent. She, not the patient, claims the right to determine whether the price to pay for life is worth it. Irony overtakes her when she discovers that she has fallen in love with a patient who has been made impotent by a hormone therapy treatment which she herself had administered, without his knowledge.

And then there is Dontsova, the middle-aged oncologist who had always believed herself a dedicated and compassionate person, but whose eyes were opened only when she discovers that she herself suffers from incurable cancer.

Such are but a few of the myriad characters who give the breath of life, with all its pains and fears and victories, to a critical period of recent history. Solzhenitsyn has created a masterwork in the tradition of Pasternak and Tolstoy. He has written in the very blood of experience, having himself been imprisoned by Stalin.

Possibly books like this cannot come out of the United States for the simple reason that one would have to have known the Russian experience to write about a people with such a limitless capacity for enduring hardship and brutal oppression. How can we possibly comprehend the experience of a nation which lost 63 million people—one-third of its population—between 1914 and 1918, only to lose another 26 million—one out of every 10 citizens—between 1939 and 1945. (By contrast, American losses in World War II numbered 307,000.)

Against that background, Solzhenitsyn once again proclaims in powerful and eloquent terms the indestructibility of the human spirit.

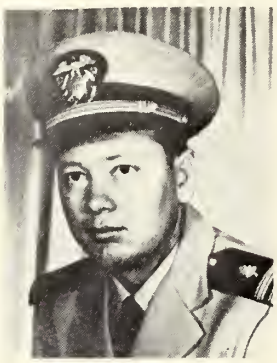
"It is not our level of prosperity that makes for happiness," Kostoglotov remarks in *Cancer Ward*, "but the kinship of heart to heart and the way we look at the world. Both attitudes lie within our power, so that a man is happy so long as he chooses to be happy, and no one can stop him."

Reviewed by Ray Jenkins, Editor, *Alabama Journal*, Montgomery.



around the state

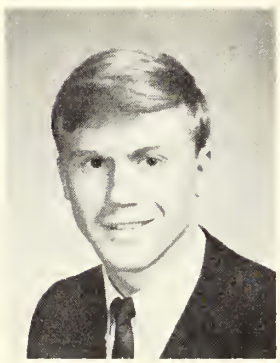
New Physicians Licensed To Practice In Alabama



John Gramling Adams, M. D., Medical College of Alabama, 1966, Reciprocity with National Board of Medical Examiners—Intends to locate in Centre.



Joseph LeRoy Broady, M. D., University of Tennessee College of Medicine, 1964, Reciprocity with Tennessee—Intends to locate in Montgomery.



Robert Lindon Baldwin, M. D., Medical College of Alabama, 1968, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



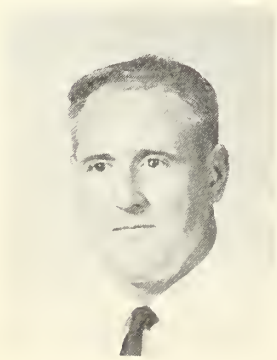
Kirby Knapp Bryant, Jr., M. D., Harvard Medical School, 1956, Reciprocity with Mississippi—Intends to locate in Anniston.



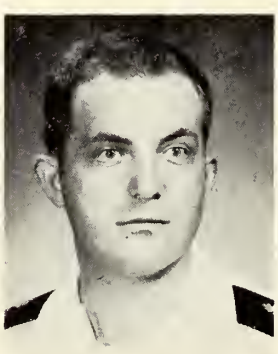
Willie Woodrow Bell, Jr., M. D., Medical College of Alabama, 1968, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Stephen Thomas Bush, M. D., Georgetown University School of Medicine, 1961, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



William Allen Bright, M. D., University of Mississippi School of Medicine, 1964, Reciprocity with Mississippi—Intends to locate in Tuscaloosa.



David Alan Cross, M. D., University of Oklahoma School of Medicine, 1968, Reciprocity with National Board of Medical Examiners—Intends to locate in Foley.

(Continued on Page 282)

fast start on a short therapeutic course



Sterazolidin®

50 mg. phenylbutazone
1.25 mg. prednisone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

Prompt anti-inflammatory action for...
relieving pain and stiffness
reducing tenderness and swelling
restoring joint movement
in bursitis, synovitis, tenosynovitis
and acute fibrositis.

Total treatment time: 7 days
Usual dosage: 2 capsules t.i.d.

Sterazolidin is valuable in the treatment of acute rheumatic conditions so often refractory to routine therapy. However, it is a potent drug, not a simple analgesic. Therefore, Sterazolidin should never be administered casually. For complete details on dosage, adverse reactions, contraindications and precautions, please see the following two pages.

Sterazolidin®

Each capsule contains:

Butazolidin®, brand of phenylbutazone	**50 mg.**
prednisone	**1.25 mg.**
dried aluminum hydroxide gel	**100 mg.**
magnesium trisilicate	**150 mg.**

Antiarthritic
Anti-inflammatory

Capsules

Important Note Butazolidin, brand of phenylbutazone, and prednisone, the active ingredients of Sterazolidin, are both potent drugs; the pharmacologic action of each should be borne in mind when Sterazolidin is prescribed. Sterazolidin combines anti-inflammatory, analgesic, antipyretic, and antiallergic properties and cannot be considered a simple analgesic and should never be administered casually. The usual warnings, precautions and contraindications associated with Butazolidin, brand of phenylbutazone, therapy and steroids apply to Sterazolidin.

Indications: *Chronic treatment of:* rheumatoid arthritis, rheumatoid spondylitis, osteoarthritis; and also treatment of acute rheumatic conditions such as bursitis, synovitis, tenosynovitis, various forms of acute fibrositis, and acute gouty arthritis.

Contraindications

Usually absolute: active, questionably healed or suspected tuberculosis, herpes simplex ophthalmia, acute psychoses or severe psychoneuroses, history of blood dyscrasia, the frankly senile patient, and active peptic ulcer.

Relative: exanthematous diseases, particularly varicella and fungal diseases (for other viral diseases, the physician must weigh the possible undesirable effects against anticipated clinical improvement), diverticulitis, recovery phase after gastrointestinal surgery, any condition complicated by cardiovascular disease, renal insufficiency, moderate or severe diabetes mellitus, thrombophlebitis, osteoporosis, convulsive disorders, thyroid disease, history of drug allergy, history of peptic ulcer, hypertension, the elderly patient, psychotic tendencies, pregnancy, except in severe disease (the safety of Sterazolidin in pregnancy has not been established), edema, and hepatic damage.

Its use in conjunction with other potent chemotherapeutic agents may greatly increase the possibility of toxic reaction, and this practice is, therefore, inadvisable. Large doses are contraindicated in patients with glaucoma.

Warning Coumarin-type anticoagulants depress prothrombin activity. This is accentuated in some cases when Butazolidin, brand of phenylbutazone, is simultaneously employed in treatment; occasional instances of severe bleeding have been reported. Patients receiving coumarin-type anticoagulants should be very carefully followed for evidence of excessive increase of prothrombin time when Sterazolidin is added to this regimen. Anticoagulant therapy can then be properly adjusted, if necessary. When prescribed alone, Sterazolidin has not been shown to influence prothrombin activity. Persistent or severe dyspepsia may be indicative of peptic ulceration. In these instances, upper gastrointestinal x-ray diagnostic tests should be performed if the drug is continued. Pyrazole compounds, such as phenylbutazone, may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Patients receiving such concomitant therapy, therefore, should be carefully observed for this effect.

Precautions and Adverse Reactions *Gluco-Corticoid Activity:* In some diabetic patients on prednisone, the insulin requirements may be increased. It is advisable to observe diabetic patients carefully during the treatment period. Since gluco-corticoids may unmask latent diabetes, all patients should be observed for this effect.

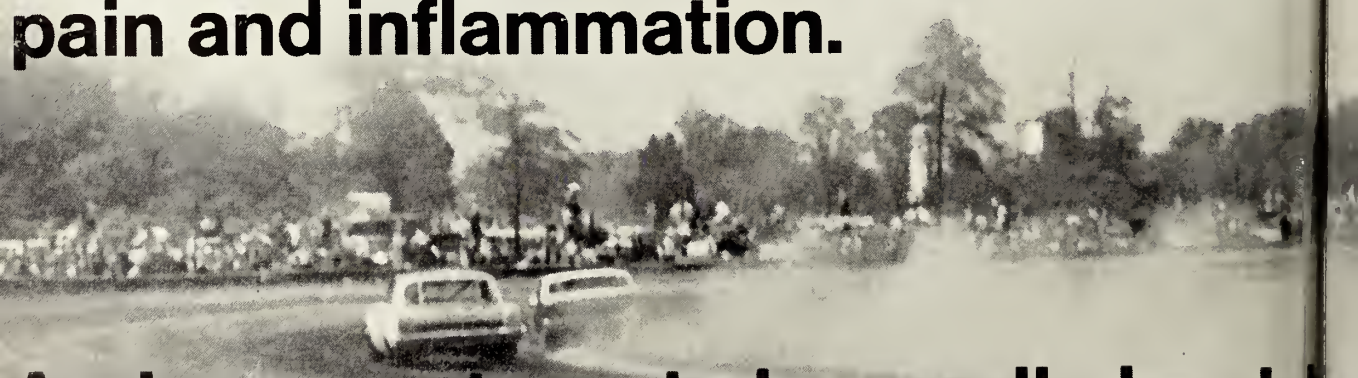
Electrolytes: Many patients receiving prednisone in average amounts show some loss of sodium, with little or no loss of potassium. With continued high dosage, however, sodium retention and potassium loss have been observed. Butazolidin, brand of phenylbutazone, has a definite tendency to produce sodium retention and hence, edema, particularly in the older age group. Elderly patients or those with hypertension, cardiac defect or renal dysfunction should therefore use Sterazolidin with special caution and the drug should be discontinued if edema develops. Development of edema may be prevented or minimized by withholding salt from the diet. Sodium retention may be counteracted with oral diuretics.

Nitrogen: With the recommended dosage of Sterazolidin, the possibility of nitrogen loss remote. However, it is recommended that patients receive adequate protein in their diet Osteoporosis or spontaneous fractures may occur with prolonged use of prednisone.

Gastrointestinal Tract: Clinical and animal studies do not indicate that the ulcerogenic activity of prednisone or Butazolidin, brand phenylbutazone, is enhanced in the combination. To overcome gastrointestinal discomf and occasional eructation in sensitive patie the medication is best taken at mealtime or with milk; Sterazolidin contains antacid co ponents to minimize the incidence of gastr complaints. All patients should be warned report immediately the occurrence of black tarry stools. The development of anemia sh immediately suggest gastrointestinal bleed

Blood Elements: Patients receiving predni. exhibit an eosinophil response similar to th seen with other steroids. During the initial weeks of treatment, Butazolidin, brand of phenylbutazone, usually causes some deg of hemodilution and resultant lowering of t red cell count. This phenomenon does not represent a true anemia and is not indicati of intolerance, but must be distinguished f true anemia secondary to gastrointestinal bleeding or other causes. With the extensi use of Butazolidin, brand of phenylbutazo rare cases of agranulocytosis have occurr (ratio less than 1 per 200,000 patients). It should also be noted that agranulocytosis occur suddenly in spite of regular, repeate normal white counts. Several cases of leu kemia and leukemoid reactions have beer reported with Butazolidin, brand of pheny butazone, therapy. Although these reactic cannot be definitely attributed to this drug possibility of a causal relationship cannot excluded. It should also be recognized th arthritic-type pains are sometimes the pre ing symptom of leukemia. Accordingly, al patients receiving Sterazolidin should ha

It's aggressive against acute arthriti pain and inflammation.



And, we want you to know all about

ou ıe periodic blood counts before and
lur g therapy. Any unexpected, significant
ha ge in the total white count, relative de-
re e in granulocytes, or appearance of
mr ture forms should be regarded as a signal
or ımediate cessation of therapy and institu-
ior f appropriate countermeasures. Thrombo-
cyt enic purpura and aplastic anemia must
als be considered possible side effects of
he py with Butazolidin, brand of phenyl-
but one.

Stress: Surgery: Prolonged use of prednisone
na cause a potentially critical degree of
adr nocortical insufficiency which may persist
eve after cessation of prednisone therapy.
The efore, if a patient is subjected to signifi-
car stress, such as surgery or trauma, either
dur g Sterazolidin therapy or within one year
aft cessation of therapy, it is advisable to
adr nister additional steroid and/or ACTH for
he uration of the stress. Delayed wound
hea ng may also occur in patients on pro-
ong d therapy.

Infections: High or prolonged doses of
pre isone interfere with the usual immune
mec anisms against bacterial and viral infec-
ion and may promote their dissemination. In
gen al, steroid treatment should not be given
in th presence of infections unless appropri-
ate tibiotic therapy is instituted at the same
imı Systemic and localized infection compli-
cati is during hormone therapy have been ob-
ser d, including fulminating pneumonia,
tub culosis, moniliasis and aspergillosis.
Shc d intercurrent infection develop, indi-
cat antibiotic therapy must be initiated
pro otly. Every patient who is to receive
ster olidin for any length of time should be
thoughly examined, including chest x-ray,
for the presence of pulmonary or extrapulmo-
nan uberculosis.

Hormonal Imbalance: Gluco-corticoids, in pro-
ıng d dosage, may cause manifestations of
hyp cortisonism or Cushing's syndrome, such
as: ponface, abnormal fat deposits, mental
dist bances, muscle weakness and atrophy,
cute eous striae, acne, ecchymoses, hirsutism,
ıer rual disturbances, edema, osteoporosis
and ontaneous fractures, and hypertension.
Thi by suppressing adrenocortical function,
thro c prednisone therapy may cause some
deg e of atrophy of the adrenal glands. There-
fore f Sterazolidin is to be discontinued, the
ıer d dosage should be tapered off gradu-
ally. In addition, it may be advisable to stimulate the adrenal glands with ACTH. Prednisone induces a prompt decrease in the urinary 17-ketosteroids. Pretreatment levels are usually regained within 7 to 14 days after cessation of therapy. Under conditions of long-term administration, a small percentage of patients on phenylbutazone may develop varying degrees of reversible thyroid hyperplasia.

Allergic Response: Development of drug rash should alert the physician to promptly discontinue the drug. The presence of prednisone in Sterazolidin may reduce the degree of allergic response; nevertheless, the same cautious attitude must be preserved with Sterazolidin as with Butazolidin, brand of phenylbutazone, if allergic manifestations occur. Other adverse reactions that have been observed with glucocorticoid therapy include: excessive appetite and weight gain, hyperidrosis, pigmentation, dry,scaly skin, thinning scalp hair, tachycardia, thrombophlebitis, headache, neuropathy (including paresthesias and neuritis), diffuse vasculitis similar to periarteritis nodosa, subcapsular cataracts, impaired renal function, lupus erythematosus-like changes, convulsions, insomnia, abdominal distention, aseptic necrosis of the femoral head, acute pancreatitis and ulcerative esophagitis.

Miscellaneous: Stomatitis and, rarely, salivary gland enlargement occasionally require the interruption of treatment with Butazolidin, brand of phenylbutazone. Adoption of a lower dosage schedule and the institution of strict oral hygiene sometimes prevent recurrence of lesions. The infrequent occurrence of such subjective sensations as vertigo or languor during therapy with Butazolidin, brand of phenylbutazone, is seldom a serious or significant complication. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis and jaundice, hypersensitivity angiitis, pericarditis and several cases of anura and hematuria. Patients should be carefully evaluated before treatment is started and those receiving Sterazolidin must remain under close medical supervision to guard against undesirable reactions such as those described. They should be instructed to report immediately the occurrence of fever, sore throat, lesions in the mouth, or black or tarry stools. It is recommended that periodic examinations of the patient include:

1. Verbal and physical examination, including blood pressure and appraisal of the cardiovascular, digestive and skeletal systems, for indications of toxic reaction.
2. Complete blood count (at weekly intervals during the first month), urinalysis, x-ray and electrolyte studies, as indicated.
3. Check of patient's weight to detect significant water retention.

Dosage Dosage should be individualized. The following general rules should be observed:

In acute therapy, dosage *should not exceed* 12 capsules on the first day and 6 to 8 capsules on succeeding days. Treatment for more than 7 days is rarely necessary. When therapy extends beyond one week, dosage should not exceed 6 capsules a day.

In chronic therapy, dosage *should not exceed* 6 capsules a day and should be tapered off gradually to establish the minimum maintenance level at which the patient still feels reasonably comfortable. A trial period of one week of therapy is considered adequate to determine the therapeutic effect of the drug. In the absence of a favorable response, therapy should be discontinued.

When switching from chronic high steroid therapy to Sterazolidin, the importance of gradual reduction of steroid dosage cannot be overemphasized. It should be kept in mind that the sterold content of 8 capsules of Sterazolidin will replace 10 mg. of prednisone (or its equivalent in related steroids).

Clinical experience indicates that most patients with rheumatoid arthritis may eventually be maintained on 3 to 6 capsules of Sterazolidin a day. It is advisable to administer the total daily requirement in divided doses.

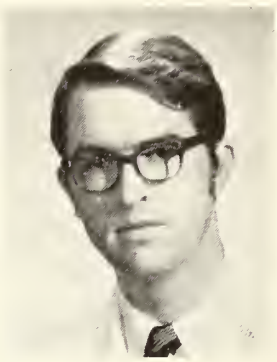
Availability Sterazolidin: Light blue and orange capsules, in bottles of 100 and 1000.
(B)46-660-B

For complete details, please see full prescribing information.

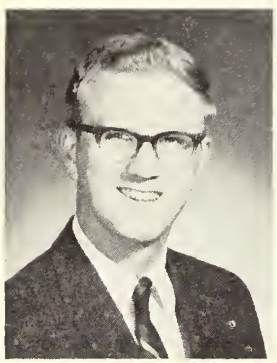
Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502



(Continued from Page 278)



William Andrew Daniel, III, M. D., Tulane University School of Medicine, 1967, Reciprocity with Louisiana—Intends to locate in Birmingham.



Robert Wayne Dettmer, M. D., Indiana University School of Medicine, 1968, Reciprocity with Indiana—Intends to locate in Birmingham.



Donald Edward Doyle, M. D., New York Medical College, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Daleville.



Mary Catherine Turner Elliott, M. D., University of Mississippi School of Medicine, 1967, Reciprocity with Mississippi—Intends to locate in Anniston.



Charles David Fritch, M. D., University of Nebraska School of Medicine, 1968, Reciprocity with Nebraska—Intends to locate in Fort Rucker.



Richard David Glasgow, M. D., Medical College of Alabama, 1968, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



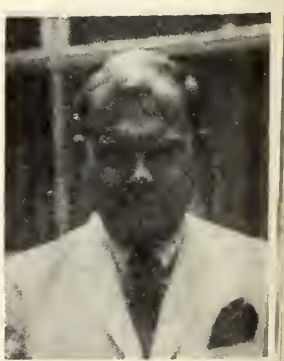
Ira Gore, M. D., Cornell University Medical College, 1937, Reciprocity with New York—Intends to locate in Birmingham.



James Lacey Gravlee, Jr., M. D., Emory University School of Medicine, 1963, Reciprocity with Georgia—Intends to locate in Birmingham.



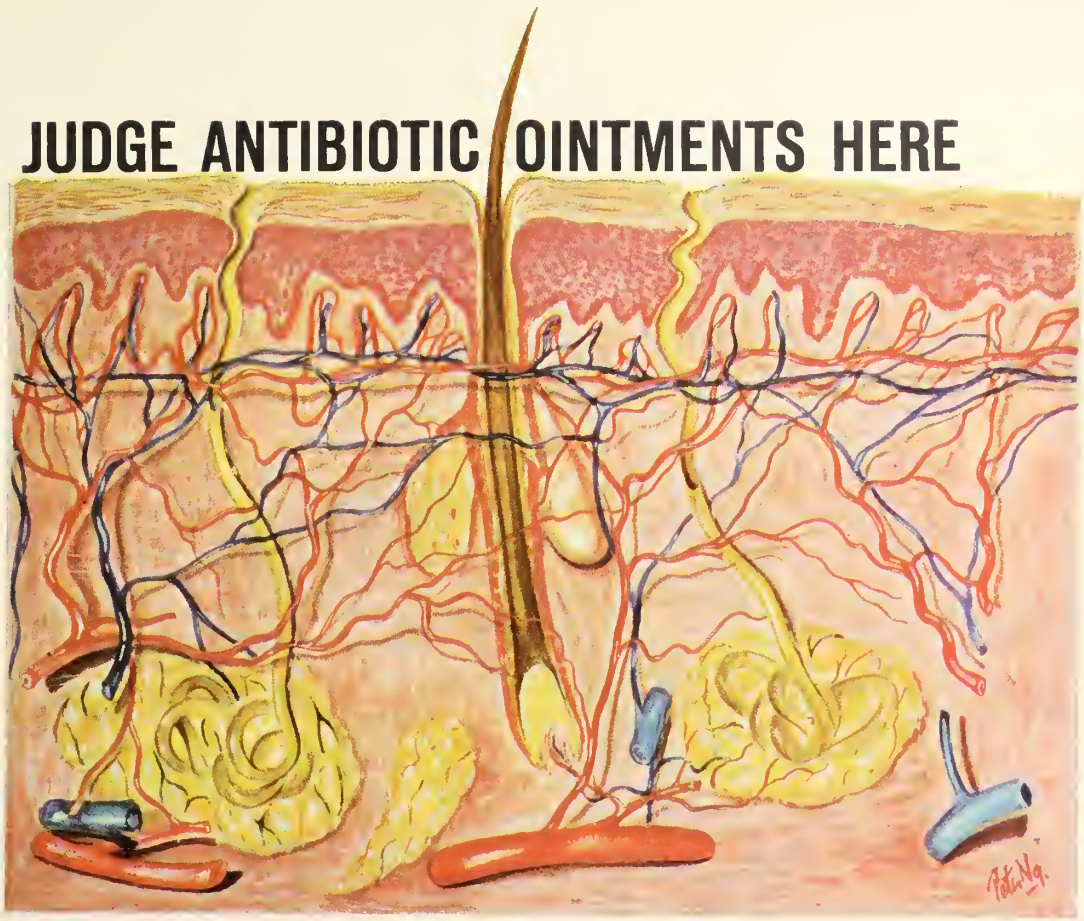
John Frederick Hilbert, M. D., Emory University School of Medicine, 1960, Reciprocity with Georgia—Intends to locate in Dothan.



Arthur Thomas Judge, Jr., M. D., Tufts University School of Medicine, 1963, Reciprocity with National Board of Medical Examiners—Intends to locate in Andalusia.

(Continued on Page 289)

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®
brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



Clues to PVD

The heavy smoker with vasospasm

He may be comparatively young or approaching middle age. Typically, he is a heavy cigarette smoker—a pack or more a day for a number of years. Whether smoking is a causative or an important exacerbating factor in peripheral vascular disease is still under discussion. But the vasoconstrictive effects of nicotine are firmly supported by a substantial body of laboratory and clinical evidence, and the close association is now generally accepted.

Thus, a history of heavy smoking coupled with vasospasm may serve as warning signals to the physician. When a diagnosis is established, therapeutic measures are directed toward increasing the local circulation, and appropriate management of the patient's general medical needs should be instituted. These include the important safeguards of keeping warm and refraining from smoking.

Before prescribing Roniacol Timespan (nicotinyl alcohol tartrate), please consult complete product information, a summary of which follows.

Indications: Conditions associated with deficient circulation; *e.g.*, peripheral vascular disease, vascular spasm, varicose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets morning and night.

How Supplied: Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt —bottles of 50.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Important in total management of peripheral vascular disease, vascular spasm or chilblains

Roniacol®
Timespan®
(nicotinyl alcohol tartrate)

for relief of ischemic symptoms

Convenience of b.i.d. dosage—sustained-release Timespan Tablets usually provide prolonged relief of ischemic symptoms with two doses daily.

Smoothness of onset—the action of Roniacol (nicotinyl alcohol) is smooth and gradual in onset, rarely causing severe flushing.

Selectivity of action—relaxes the musculature of peripheral blood vessels.

High degree of safety—side effects seldom require discontinuation of therapy.



Preludin®
phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.

Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.

Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000. (B)R3-46-560-B

Under license from Boehringer Ingelheim G.m.b.H.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502





They run a good chance of losing weight.

Exercise and Preludin run together in helping patients to lose weight.

Preludin often puts a curb on appetite and promotes a sense of well-being. By boosting a dieter's spirit, Preludin may help patients get the exercise you may prescribe.

One Endurets tablet taken between breakfast and midmorning usually provides daylong and early-evening suppression of appetite.

A few patients may experience overstimulation or insomnia. For a brief summary of all adverse reactions, precautions, warning and contraindications, please see the adjoining page.

Preludin® phenmetrazine hydrochloride

Endurets® prolonged-action tablets

Geigy

Over 225,000 Alabamians are now covered under a Blue Shield usual, reasonable and customary type program.

BLUE CROSS-BLUE SHIELD
OF ALABAMA



(Continued from Page 282)



Barry Sanford Landfield, M. D., New York University School of Medicine, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Daleville.



Abner Lynn Luther, M. D., Medical College of Alabama, 1968, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



James Greig McCully, M. D., Duke University School of Medicine, 1966, Reciprocity with Minnesota—Intends to locate in Southern Alabama (Ft. Rucker).



Elliott Fail Monroe, M. D., Medical College of Alabama, 1968, Reciprocity with National Board of Medical Examiners—Intends to locate in Mobile.



Adolphus Wimbs Plump, Jr., M. D., Meharry Medical College, 1963, Reciprocity with Georgia—Intends to locate in Birmingham.



William Daniel Potter, III, M. D., University of Mississippi School of Medicine, 1960, Reciprocity with Mississippi—Intends to locate in Gulf Shores.



Kenneth Eugene Powell, M. D., Northwestern University Medical School, 1968, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Harry Samuel Prim, Jr., M. D., Medical College of Alabama, 1968, Reciprocity with National Board of Medical Examiners—Intends to locate in Dothan.



Charles David Pritchard, M. D., University of Tennessee College of Medicine, 1962, Reciprocity with Tennessee—Intends to locate in Florence.



Darrel Estle Rains, M. D., University of Kentucky College of Medicine, 1965, Reciprocity with Kentucky—Intends to locate in Birmingham.

(Continued on Page 291)



The Bradley Center --- for the problems of living

An all new homelike open psychiatric residence on a lovely five-acre tract, centrally located within the community, providing a comprehensive range of continuous services, including in-patient, day care, and outpatient treatment. Each patient participates in an extensive and intensive treatment program, based almost exclusively upon multiple psychotherapeutic encounters. These include individual psychotherapy, group psychotherapy, the nursing milieu, occupational therapy, recreational therapy, topical small group discussions, and other group activities in the Center, as well as in the community, depending on individual needs and interests. Medications are prescribed when appropriate.

Any individual may be admitted who, in the opinion of the medical staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible family member.

Accredited by the Joint Commission on Accreditation of Hospitals.

Leonard T. Maholick, M. D.
Medical Director

Maj. Gen. (ret.) Howard Snyder
Administrator

THE BRADLEY CENTER, INC.
2000 Sixteenth Avenue
Columbus, Georgia 31901
Area Code 404 324-4882

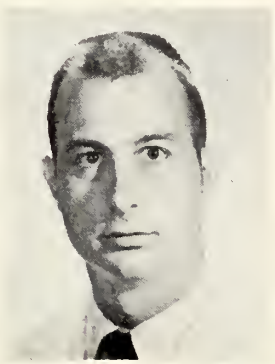
(Continued from Page 289)



Howard Samuel Reitman, M. D., University of Tennessee College of Medicine, 1963, Reciprocity with Tennessee—Intends to locate in Birmingham.



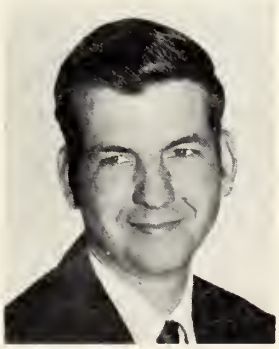
Daniel Mitchell Rencher, III, M. D., Tulane University School of Medicine, 1960, Reciprocity with Louisiana—Intends to locate in Mobile.



James Arnold Robeson, M. D., Washington University School of Medicine, 1964, Reciprocity with Missouri—Intends to locate in Birmingham.



Charles Daniel Robertson, M. D., University of Tennessee College of Medicine, 1962, Reciprocity with Tennessee—Intends to locate in Athens.



Joseph Maurice Scanlan, M. D., University of Louisville School of Medicine, 1962, Reciprocity with Kentucky—Intends to locate in Montgomery.



Joel Louis Schwartz, M. D., Hahnemann Medical College, 1965, Reciprocity with National Board of Medical Examiners—Intends to locate in Montgomery.



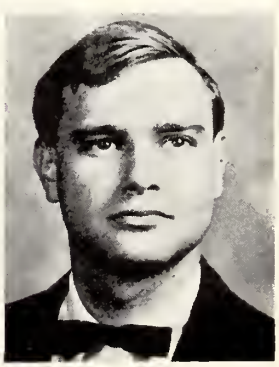
David Charles Simpson, M. D., Medical College of Alabama, 1968, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Euclid Monroe Smith, M. D., University of Arkansas School of Medicine, 1929, Reciprocity with Arkansas—Intends to locate in Hartselle.



Joseph Terrell Spencer, M. D., Medical College of Alabama, 1968, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



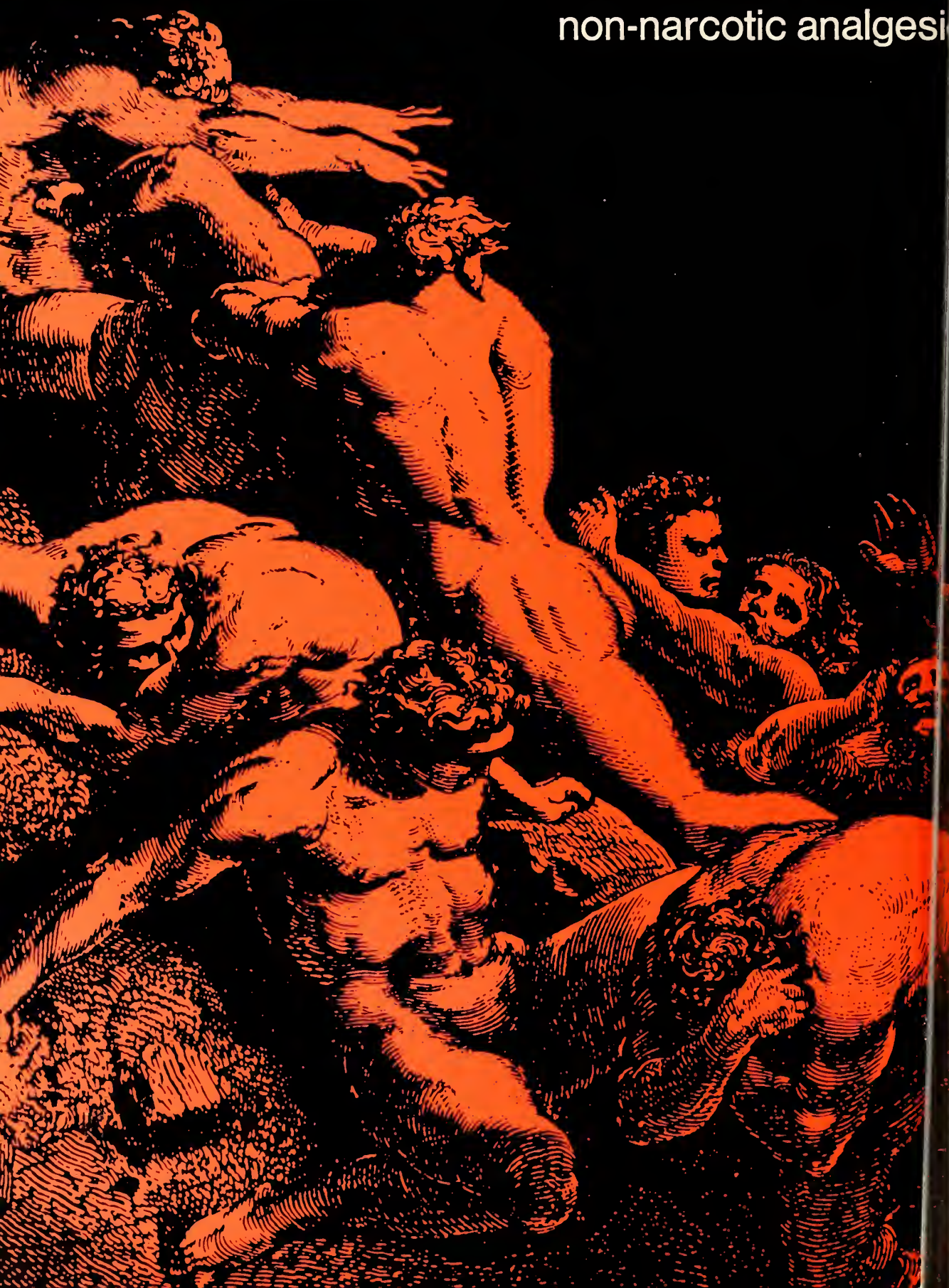
Eugene Norman Stern, M. D., University of Tennessee College of Medicine, 1968, Reciprocity with Tennessee—Intends to locate in Birmingham.

(Continued on Page 293)

NORGESIC

(orphenadrine citrate, 25 mg., aspirin, 225 mg., phenacetin, 160 mg., caffeine, 30 mg.)

non-narcotic analgesi



For musculo-skeletal pain,

try Norgesic first . . . 8 of 10 patients probably won't need anything stronger

Norgesic offers predictable relief in approximately 80% of patients with painful musculo-skeletal disorders. It provides *both* effective analgesia and relief of associated muscle spasm. Norgesic works quickly, usually producing a high level of analgesia within two hours, and relief is sustained for four hours or longer.

For the relief of acute mild to moderate pain associated with musculo-skeletal disorders, try Norgesic first...eight of ten patients probably won't need anything stronger.

Indications: Symptomatic relief of acute mild to moderate pain of musculo-skeletal origin.

Contraindications: Due to the mild anticholinergic effect of orphenadrine, Norgesic should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcers, prostatic hypertrophy, obstructions at the bladder neck, achalasia (megaesophagus), myasthenia gravis or in patients known to be sensitive to aspirin, phenacetin or caffeine. Do not use propoxyphene (Darvon®) concurrently.

Warnings: USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the childbearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

Precautions: Recent studies have indicated that prolonged excessive use of phenacetin may result in nephrotoxicity. Caution should therefore be exercised when administering Norgesic to patients with renal insufficiency. It should also be used with caution in patients with tachycardia.

Adverse reactions: Side effects of Norgesic are those usually associated with APC or mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, mental confusion in the elderly, mild central excitation and occasional hallucinations. These mild side effects are usually eliminated by reduction in dosage. One case of aplastic anemia, with no established causal relationship, has been reported.

Dosage and administration: Adults—1 to 2 tablets 3 to 4 times daily.

For more detailed prescribing information, see Package Circular or PDR.

NORGESIC®

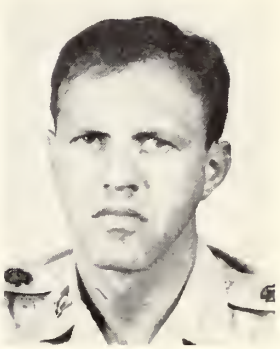
(orphenadrine citrate, 25 mg., aspirin, 225 mg., phenacetin. 160 mg., caffeine. 30 mg.)

non-narcotic analgesic

Riker Laboratories, Northridge, California 91324
Div. Dart Industries Inc.

Sponsors of Riker Service—
the complimentary classified service for physicians.

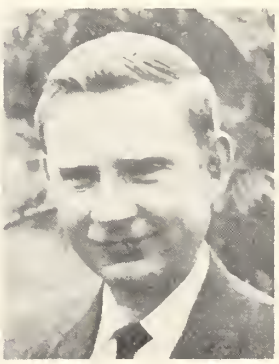
(Continued from Page 291)



William Tennant Stubenbord, M. D., Cornell University Medical College, 1962, Reciprocity with National Board of Medical Examiners—Intends to locate in Fort Rucker.



James Solomon Sullivan, M. D., Medical College of Alabama, 1968, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Cecil Charles Waddell, M. D., Medical College of Georgia, 1967, Reciprocity with Georgia—Intends to locate in Alexander City.



William Allen Webb, M. D., Emory University School of Medicine, 1962, Reciprocity with Georgia—Intends to locate in Auburn.



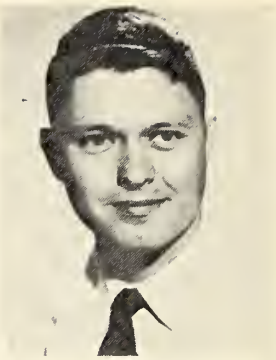
Jack Wallace Whitworth, M. D., Medical College of Georgia, 1955, Reciprocity with Georgia—Intends to locate in Shawmut.

(Next Page)

Samuel Douglas Williams, M. D., Medical College of Alabama, 1968, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Ernest Cubbage Wood, M. D., Medical College of Alabama, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Vital Statistics

NEW MEMBERS

DeKalb County

Cochran, Gerald Tyrone, b 40, mc Alabama 67, recip. NBME 68, GP, P. O. Box 5, Fyffe, Alabama 35971.

DEATHS

Colbert County

Cox, Dowlen Dorsey, Cox Building, Sheffield, Alabama—Deceased June 27, 1969.

Houston County

Hicks, Dorman Marvin, Cottonwood, Alabama—Deceased.

Macon County

Giles, Julian W., Drawer G., VA Hospital, Tuskegee, Alabama—Deceased.

CHANGE OF ADDRESS OF MEMBERS

Calhoun County

Winslow, Robert C., present Anniston to Apartment C-3 McMillan Terrace, Anniston, Alabama 36201.

Jefferson County

Dixon, Gloria Anne, present Birmingham to 557 Rutherford Circle, Birmingham, Alabama 35206.

Gray, Gene Woodrow present Birmingham to 2016 Tenth Avenue South, Birmingham, Alabama 35205.

Harris, John Wesley present Birmingham to 5350 First Avenue North, Birmingham, Alabama 35212.

Hodges, James Paschall present Birmingham to 8444 First Avenue North, Birmingham, Alabama 35206.

LeMay, Bobby Paul present Birmingham to 2620 Southview Circle, Birmingham, Alabama 35216.

Wells, Clay Norris present Birmingham to 1714 South 11th Avenue, Birmingham, Alabama 35206.

Lee County

Brock, William Michael present Opelika to 520 Dalraida Street, Montgomery, Alabama 36109.

Madison County

Ditoro, Peter present Huntsville to 930 Franklin Street, Suite 205, Huntsville, Alabama 35801.

Elwell, Hildreth Burt, Jr., present Huntsville to NASA Medical Center, A&TS MS-M, Marshall Space Flight Center, Alabama 35812.

Frierson, Wallace Brown present Huntsville to NASA Marshall Space Flight Center, Alabama 35812.

Spraul, James Howard present Huntsville to A&TS, MS-M, Marshall Space Flight Center, Alabama 35812.

Sutherland, Hugh Lewis, Jr., present Huntsville to 1369 Mary Gene Faroma Square, Memphis, Tennessee 38116.

Treadwell, Tandy Walter, Jr., present Hunts-

(Continued on Page 297)

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS



symptoms of mixed anxiety-depression are rarely clear-cut..
but they are often a clear indication for

Mellaril®
(thioridazine)
25 mg. t.i.d.

effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69 384

(Continued from Page 294)

ville to 2500 North State Street, Jackson, Mississippi 39216.

Mobile County

England, Francis Tillman present Mobile to 3167 Dauphin Street, Mobile, Alabama 36606.

Martin, Henry Floyd present Mobile to P. O. Box 117, Point Clear, Alabama 36564.

Morgan County

Payne, Louis T. present Hartselle to 819 Fourth Avenue, Tuscaloosa, Alabama 35401.

Russell County

Warr, William Spurgeon present Phenix City to 1400 Broad Street, Phenix City, Alabama 36867.

MEMBERS TRANSFERRED

Colbert County

Zickler, James Brown, 177 Monticello Drive, Florence, Alabama, from member Colbert County to member Lauderdale County.

Jefferson County

Pennington, Lloyd Franklin, Jr., 1720 Center Street, Mobile, Alabama, from member Jefferson County to member Mobile County.

NEW TELEPHONE NUMBERS

Thomas Baxter Woods, Jr., Dothan	792-9700
Foy, Robert E., Jr., Enterprise	347-1427
Garner, Joe F., Dothan	792-9700
Smith, Rufus C., Jr., Dothan	792-9700

CLASSIFIED

Doctors:

Are you tired of city traffic to hospitals, office and home? Are you fed up with racial strife? Then why not consider practicing in beautiful Nebraska? A nicer place and finer people you'll never see or meet than in Coleridge, Nebraska. Fully equipped Clinic with lab and X-ray. Ready to walk into and open. Remember—no city traffic nor smog, nor racial strife (only have one race). Call collect or write:

Mr. Elroy Hefner
Area Code 402—283-4475 or 283-4201
Coleridge, Nebraska 68727

* * *

NEEDED—One or two physicians in a good and clean community of 700 people. A good clinic is available at once, or would consider building a new clinic to physician's specifications. Twenty minutes to two excellent hospitals—potential unlimited. Great hunting and fishing. Good schools and the friendliest people in the world.

Call or write:
Mr. Lambert E. Karel, Sec.
Howells Community Club
Howells, Nebraska 68641

WANTED: General Practitioner in rural Nebraska Community. Modern facilities available. Full information upon request. Contact: Jerry L. Sheets, R. P. Elgin Drug Store, Elgin, Nebraska 68636.

* * *

WANTED: GP for private practice, solo or partner in Hamilton, Texas. Located in Central Texas, ideal hunting, fishing, and sports activities. New school facilities in a clean, modern community, ideal for raising children. Hospital privileges available. Call collect to O. C. Dill, Administrator, area code 817-386-3151 for further details, or send resume to Hamilton Hospital, Hamilton, Texas.

* * *

Opportunity to practice in quiet rural Nebraska, 1100 population, plus large trade area. Facilities available with financial backing. Golf, hunting, fishing, and boating. North Central Accredited school and six churches. Progressive modern town.

Contact:
Roger A. Pentz, D. D. S.
Box 317
Arapahoe, Nebraska

Dulcolax®...so predictable you can almost set patients by it

Dulcolax works so effectively that the time of bowel evacuation can often be predicted.

Dulcolax tablets taken at night will usually result in a convenient bowel movement the following morning. Dulcolax suppositories generally work within 15 minutes to an hour.

Dulcolax may be given to the aged, pregnant or nursing women, and children. It may be particularly helpful in conditions in which straining should be avoided. The drug, however, is contraindicated in the acute surgical abdomen.

Dulcolax® bisacodyl



NDER LICENSE FROM BOEHRINGER INGELHEIM G.M.B.H. GEIGY PHARMACEUTICALS, DIVISION OF GEIGY CHEMICAL CORPORATION, ARDSLEY, NEW YORK 10502

With Two Interns Plus Medical Students, Montgomery Moves Up To Birmingham and Mobile

Interns are in Alabama's capital city for the first time since 1936.

Montgomery's five hospitals have taken a major step forward to provide required intermediate training for the graduate M. D. to qualify to enter the practice of medicine.

From July 1, to Nov. 1, Dr. J. David Hagan, 25, native of Alexander City, and Dr. Hoyt A. Childs, Jr., 24, from Samson, Ala., are serving individual schedules of 36 hours on continuous call at Baptist Hospital and 12 hours off. From November 1 to March 1, they will transfer to St. Margaret's to be succeeded at Baptist by three senior medical students. The period from March 1 to June 30, will be elective.

Twice a week, Dr. Tinsley R. Harrison, distinguished Professor of Medicine at the University of Alabama Medical College, a specialist in Internal Medicine and Cardiovascular Diseases, accompanies the two interns and students on visits to hospitalized patients, offering suggestions, making philosophical observations, and generally coaching them in general medical procedures. Dr. Harrison's groundwork in this program has been acclaimed.

This postgraduate medical plan was initiated several years ago by the Montgomery County Medical Society through a committee consisting of Drs. Jack Kirschenfeld, chairman; John Wade and Fred Campbell. Its successor committee, headed by Dr. H. H. Hutchinson as chairman, with Drs. Kirschenfeld and George Penton, completed the program now in effect.

The entire schedule has been made the responsibility of a new organization: the Montgomery Regional Medical Foundation. The foundation board is composed of five hospital administrators: Sister Scholastica, St. Margaret's; Sister Evangelista, St. Jude's; W. Taylor Morrow, Baptist; Douglas Goode, Jackson; and J. A. Bohannon, Professional Center; and seven doctors: J. J. Kirschenfeld, Robert Dorrough, Kathleen Wickman, H. H. Hutchinson, A. S. Zdanis, Maurice



Drs. H. A. Childs, Jr., J. D. Hagan
(Interns on duty at Baptist Hospital)



J. Sawyer, W. F. McCoy
(U. of A. medical seniors on duty at St. Margaret's)

Abrams, and the chairman, William Reynolds.

The foundation proposes to expand existing medical resources through "the cooperative endeavors of the hospitals, physicians, nurses, other paramedical personnel and the allied health agencies so as to better meet the needs of the region; improvement of patient care, introduction of new medical and nursing techniques as soon as their values have been established; the more efficient use of facilities; the correction of personnel shortages by training and recruitment; the establishment of closer relationships and cooperative planning and execution of activities among the several hospitals and their staffs in this region; the planned, coherent and continuing postgraduate educational program for physicians of the region; expansion of house-officer training programs; establishment of a post-graduate training program for nurses, including training in nursing specialties; expansion of the existing training programs for nurses, technicians and other personnel; improvement of hospital medical libraries; promotion of lay health education; and the study of and preparation for area-wide hospital and health planning."

An initial grant of $38,000 had been made to the Montgomery program by the Regional Medical Program whose coordinator is Dr. Benjamin Wells of Birmingham. The State Advisory Committee of the Regional Medical Program is headed by Dr. Ross McBryde as chairman.

At the end of their tour of duty at the two hospitals here, the current interns will go into residency to qualify as specialists.

Dr. Hagan entered college with the expectation of studying engineering, but switched to pre-med after the first year. He is married to an Alexander City girl.

Dr. Childs, son of a Samson doctor, is married to a Coffee Springs girl, and they have a 14-month-old son, Hoyt Abner Childs III. The senior Dr. Childs, one of two doctors in Samson, is in General Practice and Surgery.

Actually, as there are twice as many openings for interns as there are medical college graduates to fill them, leaders of the capital city's program are elated to have two for the opening year. A three-year residency program is the next step.

The foundation will seek community participation and community support for this tax-deductible item. Offices have been opened at 2900 McGehee Road with David W. Carter as administrator.

The two medical-school seniors at St. Margaret's, who completed their two-month tour of duty last month, were William F. McCoy of Birmingham, the son of a doctor, and James Sawyer of Enterprise.

It's Not A Chattel One Can Buy

Medical care "is not a chattel," observes the Oklahoma State Medical Journal editorially, but the phrase, "providing health care," has become so popular that it is no longer recognized as inaccurate and misleading. It is apparent, continues the piece, that people generally have come to believe "that the act of making money available for professional health care is the same as *providing* that care." It is fundamental "to understand that medical care is not provided by agencies or organizations or hospitals or insurance companies or drugs or machines or computers. Medical care is provided by people . . .

"Money cannot buy medical care and institutions cannot provide it. Medical care is provided by people who possess special skills and because of this, have special obligations to society. It is crucial that our public and our colleagues clearly understand these facts and carefully analyze their significance."

"anorectal disorders"



This Rectopath Model
may help you explain certain anorectal disorders to some of your patients. It is yours on request.

See next page for details.

"anorectal disorder"

includes a range of problems. For symptomatic relief in some of these disorders consider a member of the Anusol Family...

One suppository morning and evening and after each bowel movement.

ANUSOL®

soothing, palliative relief of minor pain, itching, burning, and other associated discomforts.

Each ANUSOL suppository contains bismuth subgallate (2.25%), bismuth resorcin compound (1.75%), benzyl benzoate (1.2%), Peruvian balsam (1.8%), zinc oxide (11.0%), and boric acid (5.0%), plus the following inactive ingredients: bismuth subiodide, calcium phosphate, hydrogenated vegetable oil, and coloring in a cacao butter and white wax base.

One suppository morning and evening for 3 to 5 days.

ANUSOL-HC®

prompt reduction of inflammation plus the soothing effects of regular Anusol.

Each ANUSOL-HC suppository contains, in addition to the regular Anusol formula, 10 mg. hydrocortisone acetate.

Precautions: Prolonged use of Anusol-HC might produce systemic corticosteroid effects.

One suppository every 3 to 4 hours, or every 2 hours if symptoms are severe.

ANUGESIC®

when severe pain requires prompt relief, pramoxine HCl plus the soothing Anusol formula.

Each ANUGESIC suppository contains: 61 mg. bismuth subgallate, 47 mg. bismuth resorcin compound, 32.4 mg. benzyl benzoate, 48.6 mg. Peruvian balsam, 300 mg. zinc oxide, 135 mg. boric acid, and 25 mg. pramoxine hydrochloride. Also contains the following inactive ingredients: bismuth subiodide, calcium phosphate, white wax, benzoinated lard, hydrogenated vegetable oil, and certified coloring in a cacao butter base.

Precautions: If idiosyncratic reaction occurs, discontinue medication.
Symptomatic treatment should not be allowed to delay definitive diagnosis and therapy.

Also available: ANUSOL® OINTMENT AND ANUGESIC® OINTMENT



The Rectopath Model is available from your Warner-Chilcott representative or upon request from Warner-Chilcott Labs., Morris Plains, New Jersey 07950.

Warner-Chilcott Laboratories, Morris Plains, N. J.

IN-91-4C

Mrs. John Chenault, Dr. Pitt Honored By 'Home Folks'

Mrs. John Chenault, president of the Woman's Auxiliary of the American Medical Association, and Dr. C. Kermit Pitt, president of the Medical Association of the State of Alabama, and both of whom hail from Decatur, were honored at a buffet dinner last month by the "home folks" and, accompanying her report with a picture of the honorees, a *Birmingham News* writer wrote of it as follows:

"The party was given by the Woman's Auxiliary to the Morgan-Lawrence County Medical Societies at the home of Dr. and Mrs. George Hansberry on Brookside Drive. Over 150 guests attended . . .

"Receiving guests were Dr. and Mrs. Chenault, Dr. and Mrs. Pitt, Mrs. David Bowers, President of the Woman's Auxiliary to the Morgan-Lawrence County Medical Societies, Dr. Rhett Danley, president of the Morgan County Medical Society, Dr. J. P. Dyar, president of the Lawrence County Medical Society, and Dr. and Mrs. Hansberry.

Installed In N. Y. in July

"Mrs. Chenault, who is the 46th president of the Woman's Auxiliary, was installed as president of the 90,000-member organization of physicians' wives at the Auxiliary's annual convention in New York City in July. She served the national Auxiliary as program development chairman, by-laws chairman, first vice president, historian and national director.

"Noted for her community work, Mrs. Chenault's special interests include the Girl Scouts, the Garden Club of Alabama, Decatur Mothers Club, League of Women Voters, Woman's Chamber of Commerce, PTA and County Mental Health Association. In addition, she is active as a Red Cross water safety instructor and has participated in the Decatur Music Club, the Baptist Church and Women's Missionary Union.

"Mrs. Chenault is a member of Phi Beta Kappa, Kappa Delta Pi, Alpha Lambda Delta and Mortar Board honoraries, Zeta Phi Eta professional speech sorority, the American Association of University Women and Kappa Delta social sorority, of which she is past Alumnae Association president. She is a past president of the Southern Medical Association Auxiliary.

"Her husband, Dr. John M. Chenault, a physician specializing in general practice and surgery, is a member of the Board of Trustees of the American Medical Association and Chairman of the Board of Censors of the Medical Association of the State of Alabama, which functions as the State Board of Medical Examiners and the State Committee of Public Health. The Chenaults have five children.

Dr. Pitt active in civic affairs

"Dr. C. Kermit Pitt was born in Morgan County and returned there after his graduation from Tulane to take up the practice of pediatrics. The way in which he has entered into both the professional life of his state and nation and the civic life of his community and state is best reflected by his record: He is a Diplomate of the American Board of Pediatrics, a Fellow of the American Academy of Pediatrics, a member of AMA, of the American Thoracic Society, a charter member of the American Society of Adolescent Medicine, an Assistant Professor of Clinical Pediatrics, Medical College of Alabama, a past president of the Morgan County Medical Society, of the Decatur General Hospital (and Chief of Staff), and of the Alabama Pediatric Society, and a member of the Morgan County Society's Board of Censors.

"And for his contributions of his community and his state, he is vice chairman of the Tri-County Appalachian Commission, a past member of the board of directors and past president of the Decatur Civitan Club, a past president of the Decatur Country Club, a past director of the Decatur Boys Club, a past director of the Decatur Youth Baseball Association, a past director of the Decatur Chamber of Commerce, and 1966 Morgan County United Fund Campaign chairman.

"A member of the First Baptist Church of Decatur, he is married to the former Zelda Thompson, and they have three children."

PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. MASA members having knowledge of practice opportunities or wishing to relocate their own practices are urged to communicate with the Placement Service. For further information: write Mr. Emmett Wyatt, Executive Assistant, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama 36104, or Telephone 263-6441.

Locations Wanted

General Practice—

Age 33, Medical College of Georgia 1968, seeking parttime employment on weekends and holidays relieving a general practitioner or emergency room duties in south Alabama within reasonable commuting distance of Pensacola, Fla. LW-1

Age 38; University of Oklahoma, 1955; seeking associate, institutional or industrial practice; in town of 10,000 plus population; interest in surgery. LW-5

Age 28; University of Tennessee, 1965. LW-7

Age 27, Medical College of South Carolina, 1966; seeking location in Gadsden area or in southern part of state in town of 5-7,000 population; available July 1, 1971. LW-7/1

Age 60, University of Arkansas 1932, seeking location for general or industrial practice. Available May 1969. LW-7/3

Age 42; Medical College of Alabama 1957; seeking location in central Alabama, near Montgomery. LW-7/4

Age 34; University of Tennessee 1964; seeking associate practice. LW-7/5

Internal Medicine—

Age 59, Cornell University 1933, American Board certified, seeking group practice. LW-8

Age 31, Medical College of South Carolina 1964, Available July 1970. LW-9

Age 37, Duke University, 1956; Board certified, seeking group, associate, or institutional practice. LW-13

Age 33; University of Miami 1962; Board eligible; National Board; seeking solo, group practice, hospital practice, or industrial practice. Available July 1969. LW-13/1

Age 31; Medical College of Georgia 1963; seeking location for practice of internal medicine-cardiology. Available 1970. LW-13/2

Neurology—

Age 32, Medical College of Georgia, 1964, seeking assistant or associate, or institutional practice. LW-14

Age 31; Harvard 1962; Board eligible; National Board; seeking solo, group or associate practice. Available July 1969. LW-15

Age 30; Medical College of Alabama 1962; Board eligible; National Board; seeking solo, group, associate or institutional practice. Available January 1969. LW-16

Age 29, Indiana Univ., 1964; Board eligible; seeking assistant or associate practice in city of over 100,000 population; available July 1, 1969. LW-17/1

Obstetrics-Gynecology—

Age 49, University of Nebraska, 1943; Board certified, seeking group or institutional practice. LW-19

Age 34, Medical College of Virginia, 1961, Board eligible, seeking group or associate practice. LW-20

Age 33; University of Illinois, 1964; seeking associate practice. LW-21

Ophthalmology—

Age 33; St. Louis University, 1962; seeking solo, or associate practice; available July 1, 1969. LW-21/1

Otolaryngology—

Age 32, University of Pennsylvania 1962, seeking associate practice. Available April 1970. LW-21/2

Age 35, University of Miami 1959, seeking location in city of 150,000 plus population. Available August 1970. LW-21/3

Pathology

Age 32, University of Louisville 1966, seeking associate or institutional practice. Available July 1970. LW-21/4

Psychiatry—

Age 52, Chicago Medical School 1939; Board eligible; seeking group or institutional practice, preferably near Gulf Coast. LW-22

Radiology

Age 28; Northwestern University 1964; completing radiology residency. Available July 1971. LW-24

Surgery—

Age 33; University of Missouri, 1961; seeking group or associate practice. Available January 1969. LW-27

Age 38; Emory University, 1956; Board eligible, seeking group, associate, or institutional practice. LW-28

Age 36, Indiana University 1961; Board eligible; seeking practice in city of 100,000 plus population. Available July 1969. LW-31/1

Age 37, University of Paris 1961; seeking group or institutional practice in city of 80,000 plus population. Available July 1969. LW-31/2

Age 48; Marquette University 1943; Board eligible; seeking institutional practice in east Alabama. Available July 1969. LW-31/3

Age 31; St. Louis University 1963, American Board certified; seeking associate practice. LW-31/3

Age 48; University of Pennsylvania 1950; Board eligible; seeking solo or group practice. LW-31/4

(Continued on Page 307)

One of these disposables comes prefilled.
Its unit dose – in nonreactive glass cartridge – is premeasured.
The cartridge is clearly labeled:
drug name, strength, control number.
Even expiration date where appropriate.

You're more confident that the patient gets...





. . . just what the doctor ordered with the Tubex Closed Injection System.

Injections with the Tubex system are as easy as 1, 2, 3,

1. Select—from an extensive variety of prefilled Tubex sterile cartridge-needle units.* No multi-dose vials to bother with; no unlabeled syringes to cause confusion.

2. Inject—with a minimum of pain. Thanks to the single-use, stainless-steel needle that's both ultra-sharpened and siliconized. Aspirate simply and conveniently.

3. Throw away—empty cartridge-needle unit. Never used again, it can't transmit infection. And there's no clean-up job.

*For injectables not yet in the ever-expanding prefilled Tubex line, empty sterile cartridge-needle units are available.

TUBEX®

Closed Injection System
Hypodermic Syringe
Sterile Cartridge-Needle Unit

Wyeth® UD UNIT DOSE MEDICATION™

Wyeth Laboratories Philadelphia, Pa.

Locations Wanted

(Continued)

Age 31; Medical College of Alabama 1963; American Board certified; seeking associate practice. Available July 1970. LW-31/4

Age 36, Emory University 1959, Board certified, seeking associate practice. Available September 1970. LW-31/5

Urology—

Age 30; Louisiana State University, 1963; Board eligible, seeking associate, or group practice. LW-32

Age 31, Chicago Medical School 1963, seeking associate practice in Montgomery. Available July 1970. LW-32/1

Age 32, Albany Medical College 1962, Board eligible, seeking associate practice. Available July 1970. LW-32/2

Student Health—

Age 40, University of Oklahoma 1955, seeking institutional practice. LW-33

Physicians Wanted

Special Openings—

Specialist in the following fields: Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practitioners. 58-bed fully accredited general hospital with 91-bed addition recently completed. Modern new office space available. PW-20

Pediatrician, Internist, and ENT specialist to join a well-established group practice in a community of 40,000 in East Alabama. The community has a 125-bed accredited hospital, 32-bed extended care facility. Good transportation on interstate with quick access to metropolitan area. Will pay travel expense for interview. PW-20-1

Opportunity for ENT, Internal Medicine, and Orthopedic Surgery practitioners to join partnership at clinic located in city of 38,000 population in trade area of 150,000 population in northeast Alabama. PW-20/2

Position for full-time industrial practice at textile plant with 2,400 employees at Decatur, Alabama. PW-20/3

Internists, Board-certified or eligible. One needed now and another in 1 or 2 years. For early partnership with internist in south Alabama city of 40,000 plus population. New office building adjacent to 181-bed hospital. Practice largely hospital in-patient and Cardiology. PW-21

Opportunity for a Board certified or eligible surgeon to be associated with a Board surgeon in city of 150,000 population. PW-21/1

The Alabama Department of Mental Health is seeking several physicians. Vacancies exist at Bryce Hospital, Tuscaloosa, and Searcy Hospital, Mt. Vernon. PW-22

Obstetrician-Gynecologist—

Excellent opportunity for a trained Ob-Gyn man, who would join a two-man partnership in city of 30,000 population located in south central Alabama. Salary is proposed for the first year, with partnership thereafter. PW-25

General Practitioners—

Opportunity in town of 4,000 population in trade area of 50,000 population, located within 100 miles of two metropolitan areas in south Alabama. Industrial and farming area. 44-bed hospital. Office space and equipment available in new building with another physician. Several churches, schools, and service clubs. PW-1

For community of 1,500 population located in south Alabama near city of 12,000 population. Hospitals located within 25 miles. Office space and equipment available. Farming, cattle and textile industries in the area. Several churches and school. Civic clubs and golf courses. PW-1-1

For town of 10,000 population in county of 40,000 population located in scenic mountainous section of Northeast Alabama. Office space and equipment available. Hill-Burton hospital-nursing home. Expanding industries in top agricultural area. PW-1-2

For community of 2,000 population, plus large trade area, located in Southeast Alabama. Modern clinic, fully equipped. PW-1-3

Opportunity in port town of 1,000 plus population in population center of 10,000 located in Southeast Alabama. Clinic available. Hospital located less than 20 miles away. Recreational advantages for water sports. Expanding industrial and farming area. Churches and schools. PW-1-4

For town of approximately 1,000 population in Northwest Alabama, near Tennessee Valley waterways. New 15-bed clinic available. Centrally located near metropolitan areas. Extensive industrial developments. PW-1-5

For town of 12,500 population in trade area of 50,000 located in South Alabama. Nearest large city with population of 145,000 is 80 miles away. Two hospitals with 140 beds. Numerous small industries. Several churches and schools. Recreational activities include water sports and golf course. PW-1-6

General Practitioner to join partnership in town of 3,000 population, plus trade area of 20,000 population in northwest Alabama. Modern office building with six examining rooms. Full partnership at beginning of third year. New 30-bed Hill-Burton hospital. Salary open. PW-1/7

Opportunity in community of 3,000 population with over 8,000 population in trade area, near metropolitan area in northwest Alabama. Clinic and office equipment available. New 400-bed hospital and older hospital, and several nursing homes. PW-1/8

Meet ALAPAC's Director From The 5th Congressional District

Before there was an M. D. after his name, there was a Lt. Comdr. before it, when John Hall Nelson was separated from service in the United States Navy at the end of World War II.



Dr. Nelson

Before Pearl Harbor, this son of a Birmingham doctor had received both A. B. and B. S. degrees from Birmingham-Southern College. Four years after the war ended he received his M. D. from the University of Alabama, went on to Harvard's Postgraduate Medical School, 1953, for his Ophthalmology.

This future 5th District Director for the Alabama Medical Political Action Committee interned at the U. S. Naval Hospital in New York City (1950-51), had his residency at University Hospital, Birmingham (1954-56), interrupting the two with General Practice in Gadsden (1951-52) and in Birmingham (1953-54). Subsequently he became an instructor in Ophthalmology at the Medical College, Birmingham, and on the staffs of three Birmingham hospitals: University, Crippled Children's, and Children's; and these in Tuscaloosa: Druid City; Consultant, V. A., Bryce and Partlow.

Dr. John Hall Nelson is a member of the Tuscaloosa County Medical Society as is his brother, Robert, an Anesthesiologist.

The ALAPAC Director is married to the former Phyllis Kitowski of Grand Forks, N. D., and they are the parents of a 7-year-old daughter.

INDEX TO ADVERTISERS

Blue Cross-Blue Shield ... 288
The Bradley Center ... 290
Breon Laboratories ... 219, 220, 221, 222
Bristol Laboratories ... 254
Burroughs Wellcome ... 283

Campbell Soup Company ... 251
Classified ... 297

Geigy Pharmaceuticals ... 212, 213, 279, 280, 281, 286, 287, 298
Guest House Motel ... 207

Highland Hospital ... 237
Hynson, Westcott & Dunning ... 199

Lederle Laboratories ... 201, 214, 217, 223
Eli Lilly & Company ... 1st Cover, 240

McNeil Laboratories, Inc. ... 232
Wm. S. Merrell ... 271
Merck Sharp & Dohme ... 224, 225, 226

National Drug Company ... 2nd Cover 209, 210

Parke Davis & Company ... 231, 295
Pfizer Laboratories ... 234, 235

Riker Laboratories ... 236, 276, 277, 292, 293
A. H. Robins Company ... 205, 206, 256, 257, 258, 259, 260, 261, 266
Roche Laboratories ... 268, 269, 284, 285, 4th Cover

Sandoz ... 296
G. D. Searle Company ... 252, 253
Smith, Kline & French ... 203, 275, 3rd Cover
Strasenburgh Laboratories ... 233

Wallace Laboratories ... 272, 273, 274
Warner Chilcott ... 263, 264, 301, 302
Wyeth Laboratories ... 305, 306



For the "Cheater Eater"

Formulas: Each 'Dexamyl' *Spansule* capsule No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid (Warning, may be habit forming). Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital (Warning, may be habit forming).
Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Hyperexcitability, undue restlessness, hyperthyroidism, porphyria; in patients on MAO inhibitors.
Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence. Rarely, symptoms of toxic psychosis (hallucinations, confusion, panic states, etc.) may occur with amphetamines, usually after prolonged high dosage. In these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester.
Adverse Reactions: Overstimulation, restlessness, insomnia, g.i. disturbances, diarrhea, palpitation, tachycardia, elevated blood pressure, tremor, sweating, impotence and headache.
Supplied: In bottles of 50.

Dexamyl®

brand of dextroamphetamine sulfate and amobarbital

Spansule®

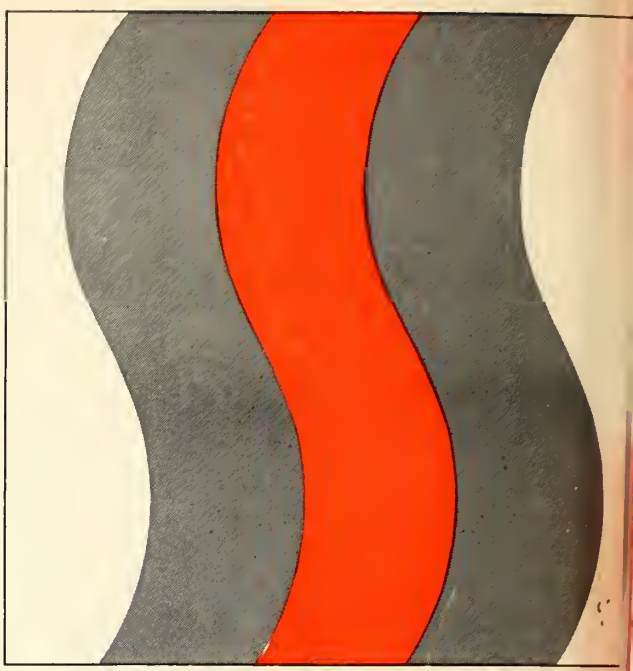
brand of sustained release capsules

curbs appetite
encourages normal activity
dispels diet discouragement

SK&F
Smith Kline & French Laboratories



from the discord of anxiety...



to emotional harmony

with the aid of antianxiety

Librium®
(chlordiazepoxide HCl)

5-mg, 10-mg and 25-mg capsules

In an age of swift change and challenge, susceptible individuals may experience varying degrees of excessive anxiety. The resulting emotional stress may precipitate significant functional disorders or complicate existing organic disease. In properly individualized maintenance dosage, Librium (chlordiazepoxide HCl) quickly helps relieve anxiety and apprehension, provides useful adjunctive therapy in psychophysiologic disorders—yet seldom impairs mental acuity or ability to function. Librium has demonstrated a wide margin of safety in short- and long-term therapy.

Also available:

Libritabs®
(chlordiazepoxide)

Roche LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, please consult complete product informotion, a summory of which fallows:

Indications: Indicated when onxiety, tension and apprehension are significont components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution potients about possible combined effects with olcohol ond other CNS depressonts. As with oll CNS-octing drugs, coution patients ogoinst hozardous occupotions requiring complete mental olertness (e.g., operoting machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution i administering to oddiction-prone individuols or those who might increase dosoge; withdrawal symptoms (including convulsions), following discontinuotian of the drug and similor to those seen with borbiturates, have been reported. Use of ony drug in pregnancy, loctotion, or in women of childbearing age requires that its potential benefits be weighed agains its possible hazards.

Precautions: In the elderly ond debilitated, ond in children over six, limit t smallest effective dosage (initially 10 mg or less per day) to preclude atax or oversedation, increasing grodually as needed and tolerated. Nat recommended in children under six. Though generally not recommended, combination therapy with other psychotropics seems indicated, carefully consider individuol phormocologic effects, particularly in use of potentiat drugs such as MAO inhibitors and phenothiazines. Observe usuol precautians in presence of impaired renol or hepotic function. Paradaxical reoctions (e.g., excitement, stimulotion and ocute roge) hove been reported in psychiotric patients and hyperoctive oggressive children. Emp usuol precautions in treotment of onxiety states with evidence of impend ing depression; suicidal tendencies moy be present and protective measur necessary. Voriable effects on blaod coagulation hove been reparted ver rorely in potients receiving the drug ond oral anticoagulonts; causal rela tionship hos not been established clinically.

Adverse Reactions: Drowsiness, otaxio ond confusion moy occur, especia in the elderly and debilitoted. These ore reversible in most instonces by proper dosage odjustment, but ore olso occosionally observed at the lov dosage ranges. In a few instonces syncope has been reported. Also encountered ore isolated instances of skin eruptions, edemo, minar menstru irregulorities, nousea ond constipation, extropyramidal symptams, increc and decreosed libido—all infrequent and generolly controlled with dosa reduction; changes in EEG potterns (low-voltage fast octivity) may appec during and ofter treotment; blood dyscrasios (including agranulacytosis), joundice ond hepatic dysfunction hove been reported occasionolly, moki periodic blood counts ond liver function tests odvisoble during pratracte therapy.

JOURNAL of the Medical Association of the State of ALABAMA



THE STATE OF ALABAMA
DISPLAY
SHELVES
23 OCT 1969

IN THIS ISSUE

The Place of Respirators in the Coronary Care Unit 355

Review of Legislative Developments Relating to Health and Medicine 367

The Use of Prisoners for Drug Trials in Alabama 396

Write it any way you please

Cordran®

Flurandrenolone



Cream Cordran contains flurandrenolone, 0.05 percent, stearic acid, cetyl alcohol, mineral oil, polyoxyl 40 stearate, ethylparaben, glycerin, and purified water.

Lilly

Additional information available upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

900415

OCTOBER 1969



Dear Doctor, You made me what I am today— a whole lot slimmer!

TEPANIL—the right start in support of t weight-control program *you* recommend. reduces the appetite. Doesn't kill it. Weig loss is significant—gradual—yet there is relatively low incidence of CNS stimu tion. Because TEPANIL works on t appetite, not on the "nerves."

Contraindications: Concurrently with MAO inhibitors, in pati hypersensitive ta this drug; in emotionally unstoble pati susceptible ta drug abuse.

Warning: Although generally safer than the amphetami use with great cautian in patients with severe hypertension severe cardiavascular disease. Da nat use during first trimeste pregnancy unless potential benefits autweigh potential risks.

Adverse Reactions: Rarely severe enaugh ta require discantinuatian af t apy, unpleasant symptams with diethylprapian hydrachlaride have been repo to occur in relatively law incidence.

As is characteristic of sympathomimetic agents, it may accasionally cause CNS effects such insomnia, nervousness, dizziness, anxiety, and jitteriness. In cantrast, CNS depressian has b reported. In a few epileptics an increase in canvulsive episodes has been reparted.

Sympathomimetic *cardiavascular effects* reparted include anes such as tachycardia, precar poin, arrhythmia, palpitation, and increased bload pressure. One published report descr T-wave changes in the ECG af a healthy young male after ingestion af diethylprapian hy chloride; this was an isolated experience, which has not been reparted by others.

Allergic phenamena reported include such canditians as rash, urticaria, ecchymosis, and erythe

Gastraintestinal effects such as diarrhea, constipatian, nausea, vamiting, ond abdominal dis fort have been reported.

Specific reparts on the hematopoietic system include two each of bone marraw depres ogranulocytasis, and leukopenia.

A variety of miscellaneaus adverse reactions have been reported by physicians. These inc complaints such as dry mouth, headache, dyspnea, menstrual upset, hair lass, muscle p decreosed libida, dysuria, and palyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallo whole, in midmarning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one haur be meals. If desired, on additianal tablet may be given in midevening ta avercame night hun Use in children under 12 years of age is not recommended.

Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride)

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144 T-918A U.S. PATENT NO. 3,001,910 5/6

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

LIBRARY OF MEDICINE
BOSTON
23 OCT 1969

BSP®



BROMSULPHALEIN® IN A STERILE, DISPOSABLE, ECONOMICAL UNIT

The Bromsulphalein test is a convenient, sensitive, reliable test of liver function.

The precalibrated syringe contained in the BSP Disposable Unit makes weight calculations unnecessary, providing proper dosage regardless of patient-weight. Each unit contains complete directions for use, precautions and contraindications.

The all-inclusive BSP Disposable Unit provides economic unit dispensing.

Complete literature available on request.

HYNSON, WESTCOTT & DUNNING, INC.

Baltimore, Maryland 21201

(BSP04)

THE JOURNAL

of the

Medical Association of the State of Alabama

Volume 39 • October, 1969 • No. 4

Office of Publication
19 So. Jackson St. .... Montgomery, Ala. 36104
Subscription Price ..... $5.00 Per Year
$1.00 Per Copy

Second Class Postage Paid at Montgomery, Alabama. Published monthly in Montgomery at 19 South Jackson Street.

Editor-in-Chief
William L. Smith, M. D. ..... Montgomery

Managing Editor
L. P. Patterson ..... Montgomery

Assistant Managing Editor
Mary Nell Williford ..... Montgomery

Associate Editors
J. P. Collier, M. D. ..... Tuscaloosa
John M. Chenault, M. D. ..... Decatur
M. Vaun Adams, M. D. ..... Mobile

Officers of the Association

President
C. Kermit Pitt, M. D. ..... Decatur

President-Elect
S. Buford Word, M. D. ..... Birmingham

Vice-Presidents
F. M. Phillippi, Jr., M. D. ..... Brewton
J. E. Cameron, M. D. ..... Alexander City
O. Emfinger, M. D. ..... Union Springs
Wood S. Herren, M. D. ..... Birmingham

Secretary-Treasurer
William L. Smith, M. D. ..... Montgomery

Executive Director
L. P. Patterson ..... Montgomery

The State Board of Censors
John M. Chenault, M. D., Chmn. ..... Decatur
J. P. Collier, M. D. ..... Tuscaloosa
Hugh E. Gray, M. D. ..... Anniston
Paul W. Burleson, M. D. ..... Birmingham
L. L. Hill, M. D. ..... Montgomery
M. Vaun Adams, M. D. ..... Mobile
J. D. Bush, M. D. ..... Gadsden
E. L. Strandell, M. D. ..... Brewton
John W. Davis, Jr., M. D. ..... Montgomery
J. Garber Galbraith, M. D. ..... Birmingham

State Health Officer
Ira L. Myers, M. D. ..... Montgomery

Delegates and Alternates to the American Medical Association

(Terms expiring December 31 of year shown.)

1970
Delegate—E. Bryce Robinson, Jr., M. D., .. Fairfield
Alternate—W. E. White ..... Anniston

1971
Delegate—M. Vaun Adams, M. D. ..... Mobile
Alternate—E. L. McCafferty, Jr., M. D. ..... Mobile
Delegate—P. W. Burleson, M. D. ..... Birmingham
Alternate—Robert Parker, M. D. ..... Montgomery

CONTENTS

President's Page 312

The Woman's Auxiliary 317

Editorial Comment 320

From the Bottom of the Ladder in Care of TB Patients 320

Of Primary Concern Is A Confused, Misguided, Victimized Public 322

Cracks In 'Building Blocks' of Socialized Medicine 323

Physician Placement Service in Alabama 330

Fathers and Sons in Medicine 333

Three Generations of Reynolds, M. D. 333

The Doctors Carl A. Grote of Huntsville 336

The Month in Washington 339

Alabama Department of Public Health 345

Health Education Curriculum Development Workshop 345

Scientific Section 355

The Place Of Respirators In The Coronary Care Unit, D. S. Tysinger, Jr.. M. D.. Dothan 355

If Life Is Prolonged, Make It Enjoyable, Ferdinand F. Schwartz, A. B., B. S., M. D., F. I. C. A., A. A. P. M. R., M. R. S. H., Birmingham 361

Association Forum 367

Review of Legislative Developments Relating To Health and Medicine 367

The Use of Prisoners For Drug Trials In Alabama 396

Around the State 413

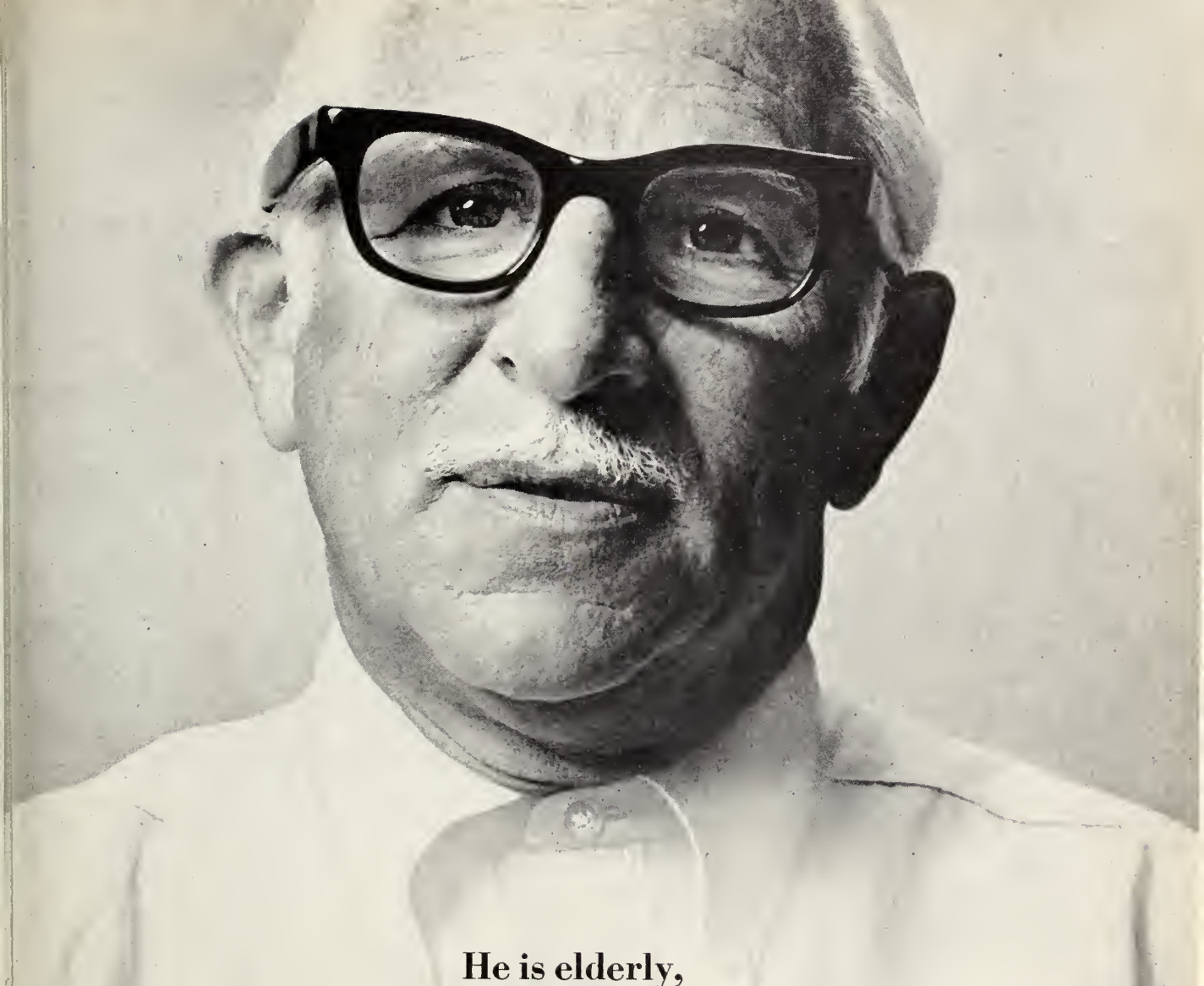
Vital Statistics 413

U. Of A. Medical Center Gets Arthritis Research Grant 418

Alabamian Chosen Vice President of ABOFP 419

A Doctor's Notebook From Yesterday .. 419

New Physicians Licensed to Practice in Alabama 421



**He is elderly,
he is on corticosteroids,
when he needs an antibiotic
he may be a candidate for**

DECLOSTATIN® 300

**Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle**

b.i.d.

guard susceptible patients against intestinal monilial overwth during broad-spectrum therapy—the protection of ytatin is combined with demethylchlortetracycline in ECLOSTATIN.

or your susceptible candidates, prescribe DECLOSTATIN e broad-spectrum therapy that prevents monilial growth.

raindication: History of hypersensitivity to demethylchlortetracy- or nystatin.

ning: In renal impairment, usual doses may lead to excessive accumun and liver toxicity. Under such conditions, lower than usual doses ndicated, and, if therapy is prolonged, serum level determinations be advisable. A photodynamic reaction to natural or artificial sunhas been observed. Small amounts of drug and short exposure may uce an exaggerated sunburn reaction which may range from erya to severe skin manifestations. In a smaller proportion, photogic reactions have been reported. Patients should avoid direct sure to sunlight and discontinue drug at the first evidence of skin mfort. Necessary subsequent courses of treatment with tetracys should be carefully observed.

autions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES, A Division of American Cyanamid Company
Pearl River, New York

President's Page

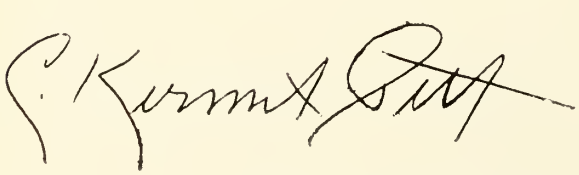


C. Kermit Pitt

In these days when so many individuals and organizations are intent on degrading the medical profession in the eyes of society as well as in those of its own members, it is well for us to remember that we are, in truth, a part of the most honorable, charitable and dedicated profession. Those who would belittle are often ill-informed, if not motivated by ulterior objectives. They constantly emphasize greed while ignoring accomplishments. The medical achievements of the last 35 years are litle less astounding than man's lunar landing. Too numerous to mention in a paper of this type, they are obvious to all.

The members of what other organization or profession train so long, labor so diligently at continuing education, devote themselves to the needs and demands of their fellows and strive with such zeal to eliminate the very problems which necessitate their skills?

The hue and cry not withstanding, those of our society most interested in the development of medical technology and the delivery of health care to our people are the members of the medical profession. This is our work and our life. The reward which we derive from this endeavor cannot be measured in terms of economics but we make no apology for the fact that "the workman is worthy of his hire" and can visualize no professional more worthy than the physician.



C. Kermit Pitt, M. D.

Taste!

Dicarbosil®
ANTACID

Your ulcer patients and others will love it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102



symptoms of mixed anxiety-depression are rarely clear-cut...

but they are often a clear indication for

Mellaril®
(thioridazine)
25 mg. t.i.d.

effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69-384

Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic/antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other depressants. As with all CNS-acting drugs, tion patients against hazardous occupation quiring complete mental alertness (*e.g.*, oper machinery, driving). Though physical and chological dependence have rarely been rep on recommended doses, use caution in ministering Librium (chlordiazepoxide h chloride) to known addiction-prone indivi or those who might increase dosage; withdr symptoms (including convulsions), follo discontinuation of the drug and similar to seen with barbiturates, have been reported of any drug in pregnancy, lactation, or in w of childbearing age requires that its pot benefits be weighed against its possible haz As with all anticholinergic drugs, an inhib effect on lactation may occur.

PRECAUTIONS: In elderly and debilit limit dosage to smallest effective amount t clude development of ataxia, oversedatic confusion (not more than two capsules pe initially; increase gradually as needed and

or here.



d). Though generally not recommended, if combination therapy with other psychotropics ems indicated, carefully consider individual rmacologic effects, particularly in use of po- tiating drugs such as MAO inhibitors and nothiazines. Observe usual precautions in sence of impaired renal or hepatic function. adoxical reactions (*e.g.*, excitement, stimula- and acute rage) have been reported in psy- atric patients. Employ usual precautions in tment of anxiety states with evidence of im- ding depression; suicidal tendencies may be ent and protective measures necessary. Vari- e effects on blood coagulation have been orted very rarely in patients receiving the g and oral anticoagulants; causal relation- o has not been established clinically.

DVERSE REACTIONS: No side effects or nifestations not seen with either compound e have been reported with Librax. When rdiazepoxide hydrochloride is used alone, wsiness, ataxia and confusion may occur, ecially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE
LABORATORIES
Division of Hoffmann-La Roche Inc
Nutley, New Jersey 07110

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69

The Woman's Auxiliary

President, Mrs. Ben H. Johnson, Jr.
President-Elect, Mrs. Howard C. Johnson
Northeast District Vice President, Mrs. James D. Holliman, Jr.
Northwest District Vice President, Mrs. Gene Qualls
Southeast District Vice President, Mrs. George Andrews
Southwest District Vice President, Mrs. Andrew D. Henderson
WAMASA Editor, Mrs. William L. Smith

AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the Medical Association of the State of Alabama. I will support its activities, protect its reputation and ever sustain its high ideals."

The Summer Board Meeting of the Woman's Auxiliary to the Medical Association was held in August in Birmingham and it was gratifying to see so many lovelies at the luncheon meeting. They came from Mobile, Ozark, Sheffield, Decatur, Anniston, Cullman, Montgomery, Tuscaloosa, and Birmingham. It was an excellent meeting, we had many important business matters to consider as well as planning of the District Workshops. The dates will be announced in the next issue of the WAMASA NEWS.

Our newsletter is one of the top ones and we are very proud of Janie Smith and her committee who devote so many hours getting it out to our membership. Also, I take this opportunity to thank the Medical Association for the contribution the Staff makes to this publication. We have four Newsletters a year filled with Auxiliary news, messages, announcements, and reports. I receive publications from other states and our WAMASA NEWS is the best of the lot. Take a look at it when it comes to your home and I know you will be proud too.

I have visited two excellent Auxiliaries recently, Blount County and Cullman County. These are both small in membership but great in accomplishment. From Blount County has come past presidents Marlys Sutton and Darlene Patton. This group always makes a terrific donation to AMA-ERF and usually is in the Award winning group. Cullman County has given us past presidents Mrs. James Daves, Sylvia Morris, and Frances Clemmons. In addition these girls have an outstanding program in providing nurses for their Hospital. They have also worked toward increasing the size of the Hospital and have accomplished their goal.



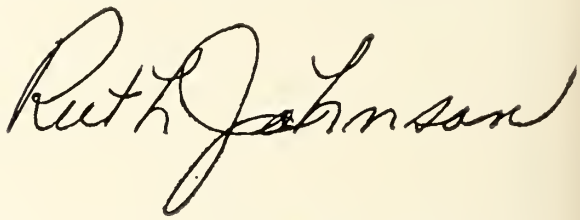
Mrs. Ben H. Johnson

It is to Auxiliaries like these that I point with pride when others say "we are too small to be effective" for here are several doctors' wives who are willing to give much of their time to Auxiliary work.

Again, I am stressing involvement of the doctor's wife in the community and the most results can be obtained through our own Auxiliary. Belong to the Auxiliary and then work with all the other worthwhile groups, help wherever you can. Be it your Church, your schools, civic projects or politics, you are doing Auxiliary work. To quote a former president, Mrs. Ira B. Patton, of the Blount

County Auxiliary, when she wrote for the Journal as State President in 1966, "Doctors' wives, make your first allegiance to your husband, and the profession he represents, by becoming more informed on the objectives of the Auxiliary. Recognize the numerous problems of your husband's profession, in order to help with a solution. You must feel a loyalty and show sincerity and enthusiasm for your endeavor to be effective." She said this so well I think it needs repeating.

And not as Thurber once told of a little girl's review of a book on birds, "This book tells me more about penguins than I need to know." We cannot know too much about our own profession, its aims, ideals, problems and goals. It takes all of us working together to have an effective Auxiliary. October is membership MONTH, DOCTORS' WIVES JOIN WITH US AND BELONG.



(Mrs. Ben H. Johnson, Jr.)
President, WAMASA

A Treasure Hunt With Safety Attachments

Almost any surgeon you could name might re-word the nursery jingle to read:

Needles and pins, needles and pins,
When a lady goes barefoot her trouble begins!

And remember, these don't count the countless numbers of bare feet that have found the needle's point at an angle sufficient to produce an outcry and a show of blood, but not sufficient to break off segments of metal inside the foot.

Most such minor wounds get no farther than the medicine cabinet for treatment, though unsanitary conditions of the area could lead the wary to the family physician, where at best the wound will be cauterized, at worst demand a precautionary tetanus shot.

Where the nap of the rug is thick and the sole of the foot is soft, disaster lurks in a needle pointed ceilingward.

Such menaces have been known to escape alike the sweeper, the vacuum, and the alert and searching eye, though they glitter like diamonds in the beam of the sun.

All of which suggests a use of the Treasure Probe for which it was never intended.

The "Treasure Probe," be it explained, is a recently developed gadget that, like a Geiger Counter in p r o x i m i t y to radio activity, changes its tune when it hovers over metal.

The contraption looks something like a flat-nosed putter, a brass shaft with a black disk at one end, a pistolgrip handle at the other. There is a battery in the handle and an ear-plug linked to the instrument by a thin cord.

It was invented for treasure-hunting. Insert the earplug, turn on the switch, tune the hum to a low, hardly audible growl, and walk around the earth, holding it perhaps six inches in the air. Wherever the disk passes over metal the low growl becomes a hysterical shriek.

If it works in the great outdoors (and it does!), why not over the bedroom carpet? It works there too, as can be demonstrated if another member of the family hides a coin under it.

Why, then, not a needle hunt? Several times a day, where the feminine contingent plies a wicked and frequent needle?

There is one fly in the ointment, one bad apple in the barrel.

In homes that are built on a reinforced slab, the hysterical shriek of the "Treasure Probe" will occur in the most unexpected places, where no metal at all is showing. But generally, it seems a pretty good safety measure.

In Logistical Control

Dr. Earle Bowen has been named to the newly created position of director of Multidisciplinary Laboratories for the new Basic Science Building, soon to be constructed in the Medical Center, University of Alabama in Birmingham.



Dr. Bowen

In a joint statement announcing the appointment, Dr. Clifton K. Meador, dean of the Medical College of Alabama, and Dr. Charles A. McCallum, Jr., dean of the UAB School of Dentistry, said, "Dr. Bowen will be responsible for the logistical, budgetary and administrative control of the new MDL. Under his direction, this new kind of laboratory should be a valuable aid to medical and dental students in better utilizing their study and research time, and enable faculty members to concentrate their instruction efforts more efficiently."

Dr. Bowen received his Ph. D. degree in physiology and biophysics through the University of Alabama in Birmingham Medical Center (1968). He was named Outstanding Medical Technology Student in 1961 when he received his M. T. (medical technologist) certificate from the University Hospital School of Medical Technology. He has a B. S. degree in biophysics from Birmingham Southern College (1961).

A native of Decatur, Alabama, Dr. Bowen served as a Porter Foundation Visiting Lecturer for the American Physiological Society (1967-68) and is author and co-author of a number of professional articles in cardiovascular research.

He is married to the former Dianne Branscomb of Birmingham. He and Mrs. Bowen have a son, Mark, who is three years old.



You can give a better ear exam EASIER with the new Hotchkiss™ Otoscope

A radical advance in otoscope design, the Hotchkiss employs the principles of modern optics to give you a brighter, clearer, more informative view of the ear canal and tympanic membrane. It weighs just five ounces (including batteries) and fits into your shirt or jacket pocket. You can carry it anywhere; use it repeatedly without fatigue. And the Hotchkiss is built to stand up to far rougher treatment than you're likely to give it.

See for yourself. Clip and mail the coupon, and our Representative will call for an appointment to show you the new Hotchkiss Otoscope in your office.

SK&F **Smith Kline & French Laboratories**

Smith Kline & French Laboratories E-30 A
1500 Spring Garden Street
Philadelphia, Pa. 19101

I would like your Representative to call for an appointment to show me the Hotchkiss Otoscope.

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

☐ Send descriptive literature



From The Bottom Of The Ladder In Care Of TB Patients

It would be an exaggeration to say that, in the care of its tuberculosis patients, Alabama is in the position of a state that still commits its mental patients to Bedlam.

But a letter to Dr. John Chenault as Chairman of the State Committee of Public Health (which is the Board of Censors of the Medical Association) from K. W. Grimley, executive secretary, the Alabama Tuberculosis Association, points up the antiquated provisions for TB patients as currently made by our State.

> Alabama now has the highest rate of newly reported cases of tuberculosis annually, and the highest tuberculosis death rate of any of the 48 contiguous states.

Alabama presently provides a subsidy of $8.25 per bed day, as contrasted with $25 in Georgia. But note this: Georgia finds only 350 tuberculosis beds necessary as contrasted with Alabama's 1,125. In money, it comes out to nearly the same total.

Responsibility for tuberculosis patients in Alabama, wrote Mr. Grimley, "rests in a bewildering, ill defined and nebulous assortment of seven Boards of Trustees of hospitals, some of these being district, some county, and some privately owned and operated—seven medical directors, 67 county boards of health, the state health officer, etc. Nowhere in the state law is responsibility for any aspect of the program strictly and specifically set out."

In contrast, Georgia has one man designated Director of the tuberculosis branch of the State Board of Health, and it operates its patient-care program under his direction with computer-guided facility.

The muddled Alabama situation is proving costly in money and human life.

Mr. Grimley sees two courses open to our state, in increasing the state subsidy—a massive increase in state tuberculosis hospital subsidy appropriations or the closing of one or more Alabama Tuberculosis Hospitals and the concentration of the present state subsidy to provide more adequate per diem for the remaining institutions. As the demands of Medicaid make the first alternative a political impossibility, the latter seems the only way open. But there is *no* existing authority in the State to require the conversion of any of the seven tuberculosis hospitals, and none of the seven could be expected voluntarily to bow out of the picture.

Legislation emerges as the only answer, and that legislation must await 1971, unless there is a special session.

It is increasingly apparent that, from the bottom of the heap of 48 contiguous states with more diseased lungs per capita than any other, concerned Alabamians, in and out of the medical profession, had better begin thinking seriously of remedial legislation.

And it might be remembered that Alabama could profit from the closing of these hospitals, converting buildings and facilities to the use of mental patients.

(Continued on Page 322)



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.



(Continued from Page 320)

Of Primary Concern Is A Confused, Misguided, Victimized Public

To Alabama's Ophthalmologists:

You may have lost a battle . . . but you made a point and reestablished a principle in your fight against the School of Optometry at the University of Alabama School of Medicine, Birmingham.

Regardless of the high purposes and liberal spirit behind the linking of a proud and progressive science with a good auxiliary service, the net result must be a confused and victimized public.

If the average ailing person makes little distinction between a licensed, practicing M. D. and a Doctor of Chiropractic, how much more is he apt to find little difference between the M. D. whose specialty is Ophthalmology, and the Optometrist who adds to his apprenticeship and experience in a glasses factory a degree from an accredited school of the Medical Center in Birmingham?

Like the paucity of practicing physicians in other specialties, the thinning ranks of the Ophthalmologist are alarming. It is the thinking Ophthalmologist's major concern. Stimulating the growth and improving the education of an auxiliary service are compulsive objectives, outside the tight confines of the medical school. There could be little objection to a School of Optometry at Troy State.

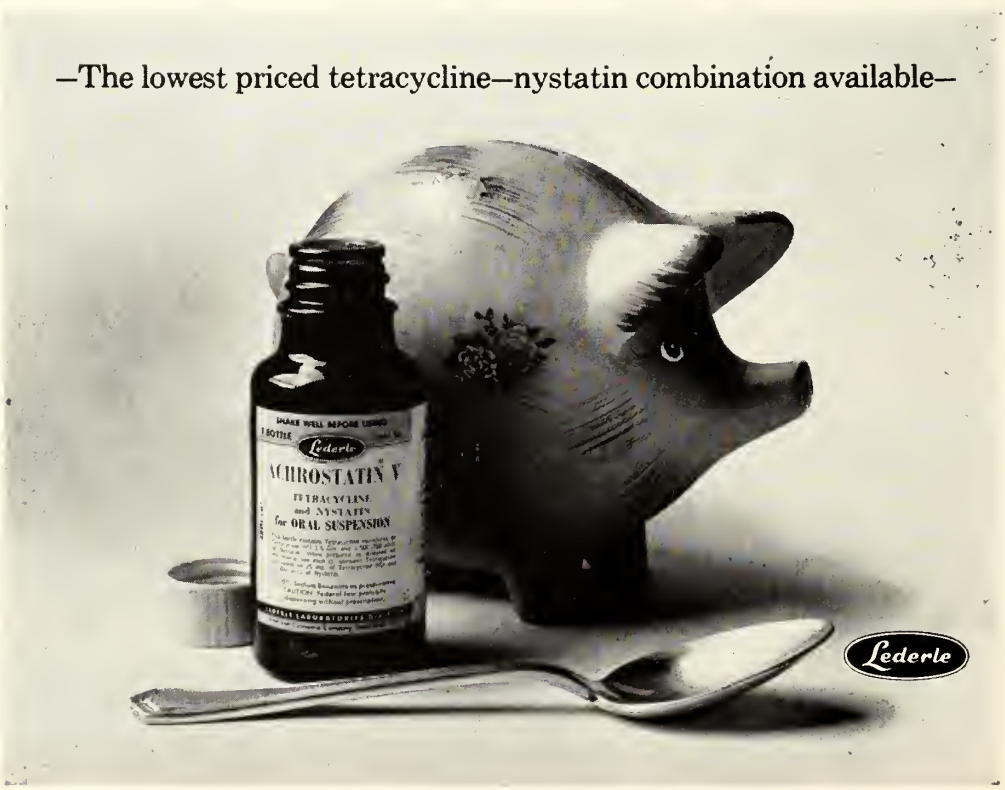
It is an almost exact paralleling situation with medicine's general opposition to liberalizing the scope of chiropractic.

The crowded offices of the M. D. whether specializing in Ophthalmology or whatever, is no more excuse for correcting glaucoma with new glasses than attacking leukemia with an adjustment for a subluxated vertebra.

Every responsible, knowledgeable person recognizes that.

But the basic problem is a confused, economically harried public, wishfully thinking to cut corners in health care, disease treatment and cost.

It is the primary responsibility of every graduate M. D., one of which no government agency can relieve him.



Cracks In 'Building Blocks' of Socialized Medicine

When the walls of Utopia come tumbling down, it is perfectly natural for the builders to cast about for somebody else to blame.

When the building-blocks for Medicare-Medicaid were finally being mortared into place in 1965, one interested party attempting to point out the bubbles in the mortar and the flaws in the blocks happened to be the one party on whom all hopes of success must rest, the medical profession.

Like OX-5 or Enzyme 7 or the patented ingredient of a soap powder, the key substance of this political structure was "comprehensive health services" guaranteed the poor to the exact same extent as that available to the more economically successful.

In the competitive free-enterprise framework of this nation, the more successful live in the biggest houses, drive the more luxurious cars, travel in the more exclusive social circles, retain the most notable legal counsel, sit in the most fashionable church pews, and become the patients of doctors with the best reputations.

Periodically these wealthy ones enter a hospital for a checkup, taking the full range of laboratory procedures and other tests, with the attendant medications, hoping they will be found in the best of health and feeling that such a finding will be a bargain, whatever the cost in money.

More than one very wealthy Alabamian, troubled with corpulence, have been known to enter a hospital annually where experts can see to their diet, direct their routines, and generally assure them of a loss of weight.

Spokesmen for the medical profession pointed these simple facts of life out to the United States Congress. The necessities of medicine, they agreed, should be provided for every American, regardless of his ability to pay.

But to attempt to make the luxuries of medicine available to all would bankrupt even this richest nation in the world.

These warnings were met with scorn and ridicule. The doctors were labeled heartless obstructionists. For entirely selfish reasons weren't they trying to withhold the wonderful benefits of modern medicine from the poorer sick and aged? The retaining walls of this ultra-modern Utopia were mortared into place.

When cracks appeared in the building blocks and bubbles burst in the mortar, do you think the engineers of Medicare and Medicaid shouldered the responsibility for their faulty structure:

They did not.

They blamed the doctors. In the midst of

(Continued on Page 324)

Not just a motel
it's a Guest House

. . . with 171 handsome rooms designed for your comfort and convenience. A center-of-everything location including Birmingham's University of Alabama Medical Center . . . making The Guest House a favorite of Doctor's wives and in-town outpatients. Superb dining, dancing and nightly entertainment. Come stay with us often.

THE RESTAURANT
THE PLAYROOM • CYPRESS ROOM
CONVENTION FACILITIES



The Guest House
MOTOR INN

PHONE 324-8653
18TH ST. &
10TH AVE., SOUTH
BIRMINGHAM, ALABAMA

"Where the Action Is!"

(Continued from Page 323)

an economic spiral, initiated by government spending and organized labor's greedy demands, when the prices of everything from bread to automobiles, from shoes to congressional expense to space exploration were skyrocketing, wasn't it obviously a medical conspiracy that hospital costs and doctors' fees were going up too?

The astonishing thing is not that the bleeding-hearts in Congress and Government, casting about for a scapegoat, turned on the medical profession. Nor that the public generally found it easy to accept the politician's indictment of the doctor.

But it is frustrating for the physician. For the years of his practice before 1965, he had been adjusting his fees to the individual patient's ability to pay. His charity was treating some indigent patients without charge. With the Government's invasion of private practice, the doctor continued to cut his customary fees for those sick at the bottom of the economic ladder.

Then the Government started making "profiles" of usual and customary charges. If a doctor charged $600 usually for certain surgical procedures, and cut the cost to $200 for the poor, then the "profile" for that procedure would immediately drop from $600 to $400.

The only answer for the surgeon in the case was to charge the poor patient the full $600, knowing he was unable to pay, and knowing he would write the entire fee off as a bad debt. But in making the full charge for fees the doctor was adding fuel to the fires of criticism, numbers to the ranks of the enemy.

The walls of Utopia are tumbling down, just as the doctors warned they would. The problem now is to avoid being buried in the debris.

"More Medicaid Scandal"

It is accepted fact that the great majority of the reading public rarely gets beyond the headline.

So there can be little doubt about who shouldered responsibility for that one, over an editorial in the Post-Herald, when the very opening paragraph would have clarified it:

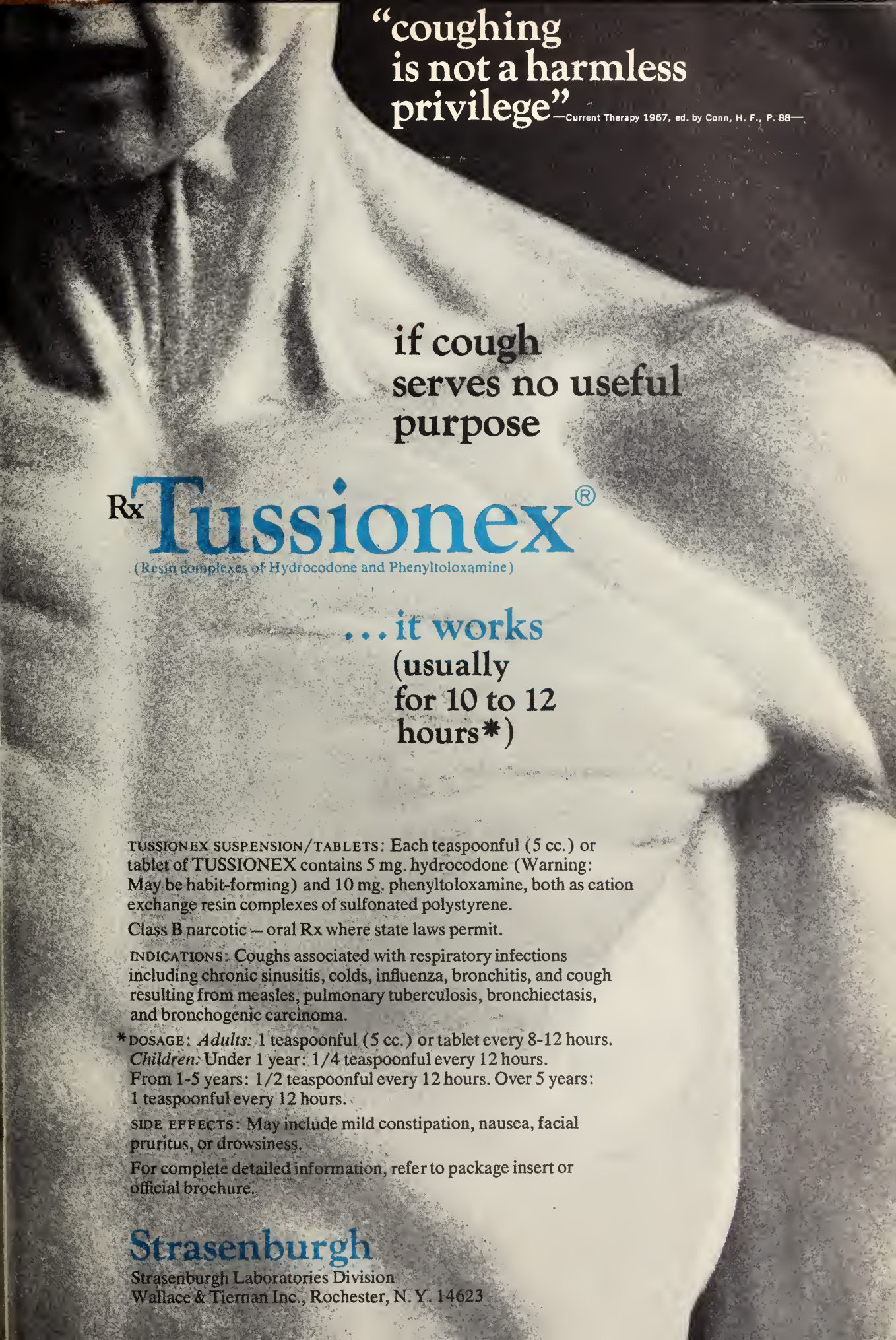
"Recent government inquiries into Medicaid programs in two of the biggest states—New York and Pennsylvania—have turned up some incredibly shoddy management." Then the piece continues:

"Just by a sampling in New York City, auditors from the Health, Education and Welfare Department found that 18 per cent of those on Medicaid were ineligible, that no effort had been made to prosecute several hundred persons who got on the rolls through fraud, that the Federal Government had been gypped of $234,292 by 'erroneous computation' of hospital rates—and so on."

Of course there were examples of overcharges "by doctors, dentists, and druggists," but when one finds that the grand total of those doctors, dentists, and druggists under a cloud in the whole of New York City comes to 21, the astonishing thing is the clean skirts of these professions of medicine, dentistry and pharmacy.

Hope Joins War On Leukemia

The treatment of acute leukemia, comments an article in the Illinois Medical Journal, "has come a long way in the past 20 years since the advent of Aminopterin, but not far enough. Success has attended the search for more effective ways" of treating the disease, "and the result has been a considerable increase in survival time. This is a good beginning down a long and arduous road and the destination—cure of the child with leukemia—no longer seems beyond reach."



TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic — oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

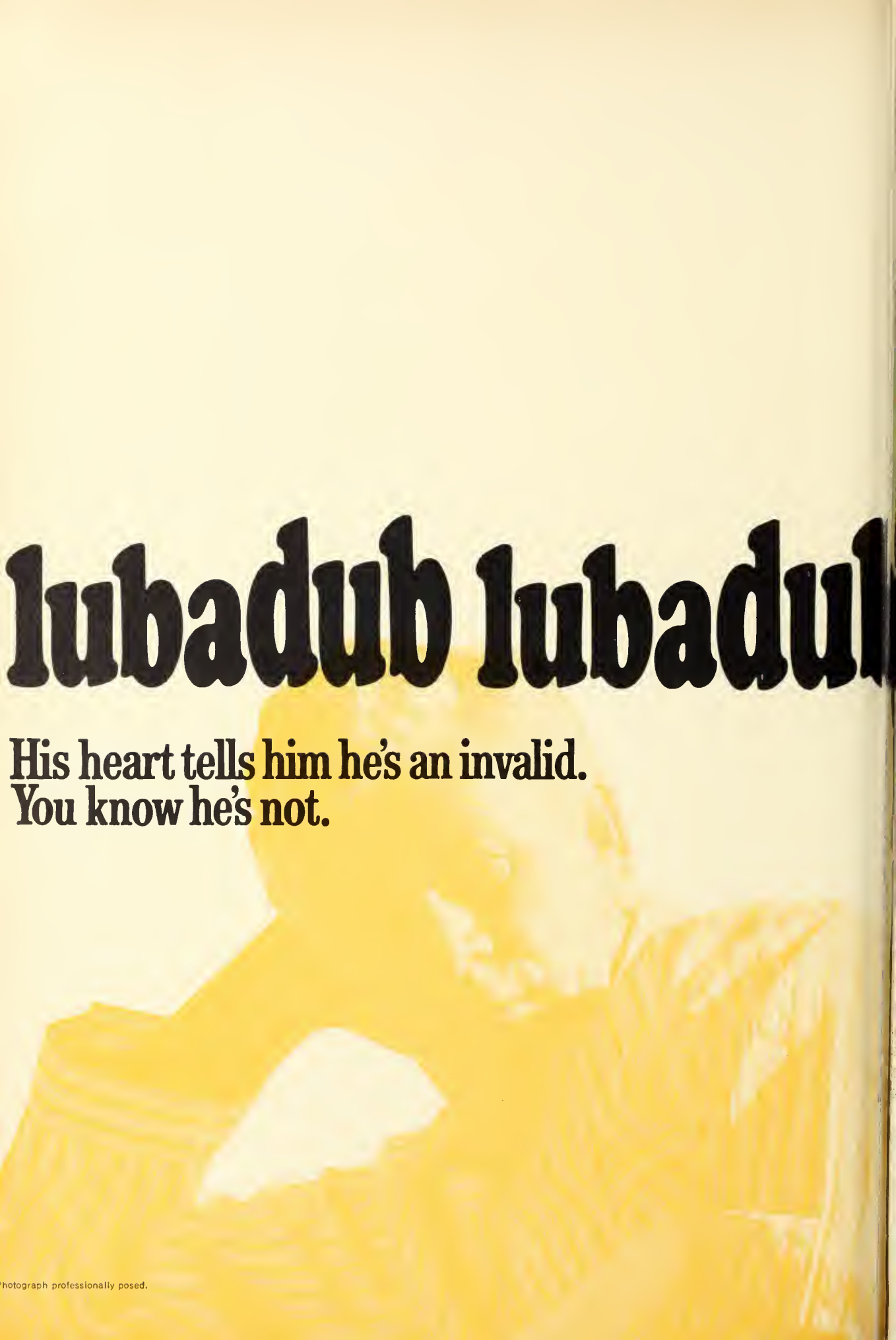
For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N. Y. 14623

lubadub lubadub

His heart tells him he's an invalid.
You know he's not.



Photograph professionally posed.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis,

ıbadubdub lubad

ıxiety is expected in the cardiovascular patient.
little may even be desirable.

ıt when anxiety is exaggerated . . . when it
erferes with sleep . . . when it aggravates
rdiovascular symptoms, your help may
needed.

aturally, you'll want to reassure the patient.

ıd perhaps prescribe Equanil (meprobamate)
adjunctive therapy. It helps relieve anxiety
d tension specifically, yet gently.

most 15 years' use has shown that Equanil
usually well tolerated as well as effective.
de effects are generally limited to transient
owsiness; serious, therapy-interrupting
de effects are rare.

stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

Equanil®
(meprobamate) Wyeth®



No place for beginners

Terramycin®
(oxytetracycline)

An infection of rapid onset requiring prompt attention. Teenage girl with chills, fever, abdominal pain, backache and nausea. Frequent and urgent urination with burning. On examination—tenderness over kidney. Blood count and urinalysis confirm the diagnosis: acute pyelonephritis. Treatment is initiated with Terramycin. Within a few days of follow-up therapy, the patient is markedly improved. The pretreatment urine culture shows a strain of *E. coli* highly susceptible to Terramycin.

Experience has shown that Terramycin offers special advantages in treating urinary tract infections when strains of causative bacteria are susceptible. Broad-spectrum coverage unaffected by penicillinase. Effective tissue levels to help reach foci of infection in renal parenchyma. High urine levels—excreted by kidney in *active* form.

With Terramycin, you have the assurance that comes with choosing an agent physicians have depended on for over 18 years. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Contraindicated: In individuals hypersensitive to oxytetracycline.

Warnings: Reduce usual oral dosage and consider antibiotic serum level determinations in patients with impaired renal function.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight; if such reactions occur, discontinue therapy.

Note: With oxytetracycline, phototoxicity is unknown and photoallergy very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy. Increased intracranial pressure in infants is a possibility. Symptoms disappear upon discontinuation of therapy.

Adverse Reactions: Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.

Supply:* Terramycin Capsules: oxytetracycline HCl, 250 mg. and 125 mg. Terramycin Syrup: calcium oxytetracycline, 125 mg. per 5 cc. Terramycin Pediatric Drops: calcium oxytetracycline, 100 mg. per cc.

*All potencies listed are in terms of the standard, oxytetracycline.

More detailed professional information available on request.



Terramycin®
(oxytetracycline)

Pfizer LABORATORIES DIVISION
New York, N.Y. 10017

PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. MASA members having knowledge of practice opportunities or wishing to relocate their own practices are urged to communicate with the Placement Service. For further information: write Mr. Emmett Wyatt, Executive Assistant, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama 36104, or Telephone 263-6441.

Locations Wanted

General Practice—

Age 33, Medical College of Georgia 1968, seeking parttime employment on weekends and holidays relieving a general practitioner or emergency room duties in south Alabama within reasonable commuting distance of Pensacola, Fla. LW-1

Age 38; University of Oklahoma, 1955; seeking associate, institutional or industrial practice; in town of 10,000 plus population; interest in surgery. LW-5

Age 28; University of Tennessee, 1965. LW-7

Age 27, Medical College of South Carolina, 1966; seeking location in Gadsden area or in southern part of state in town of 5-7,000 population; available July 1, 1971. LW-7/1

Age 60, University of Arkansas 1932, seeking location for general or industrial practice. Available May 1969. LW-7/3

Age 42; Medical College of Alabama 1957; seeking location in central Alabama, near Montgomery. LW-7/4

Age 34; University of Tennessee 1964; seeking associate practice. LW-7/5

Internal Medicine—

Age 59, Cornell University 1933, American Board certified, seeking group practice. LW-8

Age 31, Medical College of South Carolina 1964, Available July 1970. LW-9

Age 37, Duke University, 1956; Board certified, seeking group, associate, or institutional practice. LW-13

Age 33; University of Miami 1962; Board eligible; National Board; seeking solo, group practice, hospital practice, or industrial practice. Available July 1969. LW-13/1

Age 31; Medical College of Georgia 1963; seeking location for practice of internal medicine-cardiology. Available 1970. LW-13/2

Neurology—

Age 32, Medical College of Georgia, 1964, seeking assistant or associate, or institutional practice. LW-14

Age 31; Harvard 1962; Board eligible; National Board; seeking solo, group or associate practice. Available July 1969. LW-15

Age 29, Indiana Univ., 1964; Board eligible; seeking assistant or associate practice in city of over 100,000 population; available July 1, 1969. LW-17/1

Obstetrics-Gynecology—

Age 49, University of Nebraska, 1943; Board certified, seeking group or institutional practice. LW-19

Age 34, Medical College of Virginia, 1961, Board eligible, seeking group or associate practice. LW-20

Age 33; University of Illinois, 1964; seeking associate practice. LW-21

Ophthalmology—

Age 33; St. Louis University, 1962; seeking solo, or associate practice; available July 1, 1969. LW-21/1

Otolaryngology—

Age 32, University of Pennsylvania 1962, seeking associate practice. Available April 1970. LW-21/2

Age 35, University of Miami 1959, seeking location in city of 150,000 plus population. Available August 1970. LW-21/3

Pathology

Age 32, University of Louisville 1966, seeking associate or institutional practice. Available July 1970. LW-21/4

Radiology

Age 28; Northwestern University 1964; completing radiology residency. Available July 1971. LW-24

Age 43; Louisiana State University 1953; Board certified, seeking associate practice, preferably in southern section of state. Available January 1970. LW-24/1

Surgery—

Age 33; University of Missouri, 1961; seeking group or associate practice. Available January 1969. LW-27

Age 38; Emory University, 1956; Board eligible, seeking group, associate, or institutional practice. LW-28

Age 36, Indiana University 1961; Board eligible; seeking practice in city of 100,000 plus population. Available July 1969. LW-31/1

Age 37, University of Paris 1961; seeking group or institutional practice in city of 80,000 plus population. Available July 1969. LW-31/2

Age 48; Marquette University 1943; Board eligible; seeking institutional practice in east Alabama. Available July 1969. LW-31/3

Age 31; St. Louis University 1963, American Board certified; seeking associate practice. LW-31/3

Age 48; University of Pennsylvania 1950; Board eligible; seeking solo or group practice. LW-31/4

Locations Wanted

(Continued)

Age 31; Medical College of Alabama 1963; American Board certified; seeking associate practice. Available July 1970. LW-31/4

Age 36, Emory University 1959, Board certified, seeking associate practice. Available September 1970. LW-31/5

Urology—

Age 30; Louisiana State University, 1963; Board eligible, seeking associate, or group practice. LW-32

Age 31, Chicago Medical School 1963, seeking associate practice in Montgomery. Available July 1970. LW-32/1

Age 32, Albany Medical College 1962, Board eligible, seeking associate practice. Available July 1970. LW-32/2

Student Health—

Age 40, University of Oklahoma 1955, seeking institutional practice. LW-33

Physicians Wanted

Special Openings—

Specialist in the following fields: Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practitioners. 58-bed fully accredited general hospital with 91-bed addition recently completed. Modern new office space available. PW-20

Pediatrician, Internist, and ENT specialist to join a well-established group practice in a community of 40,000 in East Alabama. The community has a 125-bed accredited hospital, 32-bed extended care facility. Good transportation on interstate with quick access to metropolitan area. Will pay travel expense for interview. PW-20-1

Opportunity for ENT, Internal Medicine, and Orthopedic Surgery practitioners to join partnership at clinic located in city of 38,000 population in trade area of 150,000 population in northeast Alabama. PW-20/2

Position for full-time industrial practice at textile plant with 2,400 employees at Decatur, Alabama. PW-20/3

Internists, Board-certified or eligible. One needed now and another in 1 or 2 years. For early partnership with internist in south Alabama city of 40,000 plus population. New office building adjacent to 181-bed hospital. Practice largely hospital in-patient and Cardiology. PW-21

Opportunity for a Board certified or eligible surgeon to be associated with a Board surgeon in city of 150,000 population. PW-21/1

The Alabama Department of Mental Health is seeking several physicians. Vacancies exist at Bryce Hospital, Tuscaloosa, and Searcy Hospital, Mt. Vernon. PW-22

General Practitioner, Internist or Ob-Gyn, for partnership, associate or private practice in Birmingham. PW-26

Opportunity for GP to join well established four-man partnership; three general practitioners and one board certified surgeon. Practice located in city of 8,000 population, trade area of 60,000, north-central Alabama. Modern new partnership-owned offices adjacent to modern 125-bed fully accredited hospital. Salaried first year with possible partnership status at end of first year. PW-27

Obstetrician-Gynecologist—

Excellent opportunity for a trained Ob-Gyn man, who would join a two-man partnership in city of 30,000 population located in south central Alabama. Salary is proposed for the first year, with partnership thereafter. PW-25

General Practitioners—

Opportunity in town of 4,000 population in trade area of 50,000 population, located within 100 miles of two metropolitan areas in south Alabama. Industrial and farming area. 44-bed hospital. Office space and equipment available in new building with another physician. Several churches, schools, and service clubs. PW-1

For community of 1,500 population located in south Alabama near city of 12,000 population. Hospitals located within 25 miles. Office space and equipment available. Farming, cattle and textile industries in the area. Several churches and school. Civic clubs and golf courses. PW-1-1

For town of 10,000 population in county of 40,000 population located in scenic mountainous section of Northeast Alabama. Office space and equipment available. Hill-Burton hospital-nursing home. Expanding industries in top agricultural area. PW-1-2

For community of 2,000 population, plus large trade area, located in Southeast Alabama. Modern clinic, fully equipped. PW-1-3

Opportunity in port town of 1,000 plus population in population center of 10,000 located in Southeast Alabama. Clinic available. Hospital located less than 20 miles away. Recreational advantages for water sports. Expanding industrial and farming area. Churches and schools. PW-1-4

For town of approximately 1,000 population in Northwest Alabama, near Tennessee Valley waterways. New 15-bed clinic available. Centrally located near metropolitan areas. Extensive industrial developments. PW-1-5

For town of 12,500 population in trade area of 50,000 located in South Alabama. Nearest large city with population of 145,000 is 80 miles away. Two hospitals with 140 beds. Numerous small industries. Several churches and schools. Recreational activities include water sports and golf course. PW-1-6

(Continued on Page 332)

Physicians Wanted

(Continued from Page 331)

General Practitioner to join partnership in town of 3,000 population, plus trade area of 20,000 population in northwest Alabama. Modern office building with six examining rooms. Full partnership at beginning of third year. New 30-bed Hill-Burton hospital. Salary open. PW-1/7

Opportunity in community of 3,000 population with over 8,000 population in trade area, near metropolitan area in northwest Alabama. Clinic and office equipment available. New 400-bed hospital and older hospital, and several nursing homes. PW-1/8

For town of 2,000 population in trade area of 7,000 population located in west Alabama. Physician recently died. Nearest city is 30 miles away. Medical facilities include Hill-Burton hospital and nursing home. Churches, schools, civic clubs, and recreational advantages. PW-1/9

For town of 1,800 population located in southeast Alabama in a population center of 10,000 population. PW-1/10

For town of 7,000 population located in population center of 15,000 population located in northeast Alabama. Office space and equipment available. Hospitals located in adjoining towns within 12 miles. State University located in the town. PW-1/11

For town of 2,500 population located in northeast Alabama. 17-room modern brick clinic fully equipped. Hospital nearby. Excellent schools and recreational advantages, water sports. PW-1/12

For town of 5,000 population, located in northwest Alabama. 55-bed hospital being completely renovated, and an adjoining 69-bed nursing home. PW-1/13

Opportunity in well situated central Alabama county, trade area of 18,000 population, manufacturing, mining, farming region. New office building furnished. 33-bed accredited hospital. Excellent recreational facilities including new country club. PW-1/14

Opportunity for group practice in town of 10,000 population in north Alabama. PW-2

Physician wanted to join 39 year old Medical College of Alabama graduate in a well established general practice in West Central Alabama town. Salary initially followed soon by full partnership. PW-3

Physician wanted to join well established partnership in Northwest Alabama city of 15,000 population. Two accredited hospitals, junior college, schools, churches, recreational activities. No obstetrics or surgery. New office building. PW-7

For city of approximately 15,000 population in north Alabama, with trade area of approximately 45,000 population. Hospital with over 100 beds, and expansion planned for next year. Nursing homes in the area. Industrial growth and agricultural region. Several churches and schools. Golf course, civic and fraternal organizations. PW-8

For city of 5,000 population located 80 miles northwest of Birmingham. Industrial area. JCAH certified hospital facilities of 70 beds. Office space available for $200 per month. Guaranteed income. One physician in city desires partner, no investment, or associate. PW-1/15

For community of 2,000 population located in central Alabama, 30 miles southeast of Birmingham. Farming area. Clinic available. PW-1/16

For town of 3,600 population in trade area of 5,000-7,000 within 100 miles of two large cities and the Gulf Coast. 50-bed hospital located in the town. Office space available. Agricultural and expanding industrial area. Several churches and two schools. Recreational activities in the town as well as nearby—golf course, hunting and fishing. PW-17

Unusual opportunity for two general practitioners with military obligations satisfied at a modern fifty bed facility located 15 minutes drive from largest metropolitan center in north-central Alabama. Construction of a new two-story office building is scheduled to begin soon. PW-18

Opportunity in city of 5,000 population located in Northeast Alabama in trade area of approximately 10,000 population. Office space available. One physician died recently. Hospital and nursing home in the city. PW-19

Fathers and Sons in Medicine

Three Generations of Reynolds, M. D.

There are five physicians named Reynolds presently in the Medical Association of the State of Alabama. But only one of the five is of that line that began 150 years ago with the birth of his grandfather—in the same month of the same year that the State of Alabama was admitted to the Union—December, 1819.

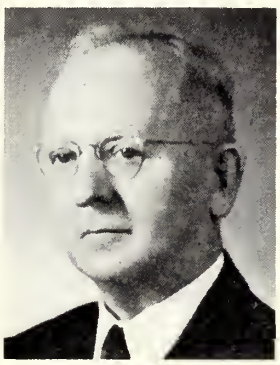
This direct line of doctors will end with the grandson, who will be celebrating his 80th birthday about the time the MASA membership is receiving this issue of the Journal of the Medical Association—on Oct. 8th.

The father: Dr. John Adams Reynolds, 1819; the son: Dr. James Walker Reynolds, 1859; the grandson: Dr. Fred Dawson Reynolds, 1889.

All three served their years of active practice in Alabama, though the grandfather was born in Montgomery, N. C., brought to this state in childhood, and conducted his extensive practice from his plantation five miles from Clio, in Barbour County, where the son, James Walker Reynolds was born.

This son spent a year at Auburn and the next year (1882) teaching school while he studied medicine under his father and older brother, Dr. Robert Reynolds. He was graduated in medicine from Mobile Medical College in 1885 and began the practice of medicine in Skipperville, Dale County, where his son Fred was born four years later.

With his baccalaureate from the University of Alabama, dated 1909, Fred Dawson Reynolds earned his M. D. three years later from Johns Hopkins, Baltimore. His internship and residency spanned the time between then and the British need for a physician



Dr. F. D. Reynolds



Dr. J. W. Reynolds

in Pittsburgh to examine the flow of patriotic American boys into that Army while this country hesitated on the brink of war.

A U. S. Medical Corps captain, he returned to the States in June, 1919, and 11 days later accepted a position with the Alabama State Board of Health as assistant State epidemaologist, resigning that place in 1920 to begin private practice in Montgomery, from which he retired five years ago following a laryngectomy (1956), and deteriorating health since then, highlighted by glaucoma and a progressive deafness.

Dr. Fred Reynolds was a 50-year-old bachelor in 1940 when he married Violet Barnett of Memphis. Mrs. Reynolds was the first President of the Woman's Auxiliary to the Montgomery County Medical Society when it was organized 21 years ago, and was state President of the Woman's Auxiliary of the Medical Association, 1951-52. She has been Secretary-Bookkeeper of ALAPAC since November, 1965, but in June of this year was forced by her husband's physical condition to relinquish her secretarial duties. They have no children.

(Continued on Page 336)

NORGESIC

(orphenadrine citrate, 25 mg., aspirin, 225 mg., phenacetin, 160 mg., caffeine, 30 mg.)

non-narcotic analgesic



For musculo-skeletal pain,

try Norgesic first . . . 8 of 10 patients probably won't need anything stronger

NORGESIC offers predictable relief in approximately 80% of patients with painful musculo-skeletal disorders. It provides *both* effective analgesia and relief of associated muscle spasm. NORGESIC works quickly, usually producing a high level of analgesia within two hours, and relief is sustained for four hours or longer.

For the relief of acute mild to moderate pain associated with musculo-skeletal disorders, try NORGESIC first...eight of ten patients probably won't need anything stronger.

Indications: Symptomatic relief of acute mild to moderate pain of musculo-skeletal origin.

Contraindications: Due to the mild anticholinergic effect of orphenadrine, NORGESIC should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcers, prostatic hypertrophy, obstructions at the bladder neck, achalasia (megaesophagus), myasthenia gravis or in patients known to be sensitive to aspirin, phenacetin or caffeine. Do not use propoxyphene (Darvon®) concurrently.

Warnings: USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the childbearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

Precautions: Recent studies have indicated that prolonged excessive use of phenacetin may result in nephrotoxicity. Caution should therefore be exercised when administering NORGESIC to patients with renal insufficiency. It should also be used with caution in patients with tachycardia.

Adverse reactions: Side effects of NORGESIC are those usually associated with APC or mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, mental confusion in the elderly, mild central excitation and occasional hallucinations. These mild side effects are usually eliminated by reduction in dosage. One case of aplastic anemia, with no established causal relationship, has been reported.

Dosage and administration: Adults—1 to 2 tablets 3 to 4 times daily.

For more detailed prescribing information, see Package Circular or PDR.

NORGESIC®

(orphenadrine citrate, 25 mg., aspirin, 225 mg., phenacetin. 160 mg., caffeine. 30 mg.)

non-narcotic analgesic

Riker Laboratories, Northridge, California 91324
Div. Dart Industries Inc.

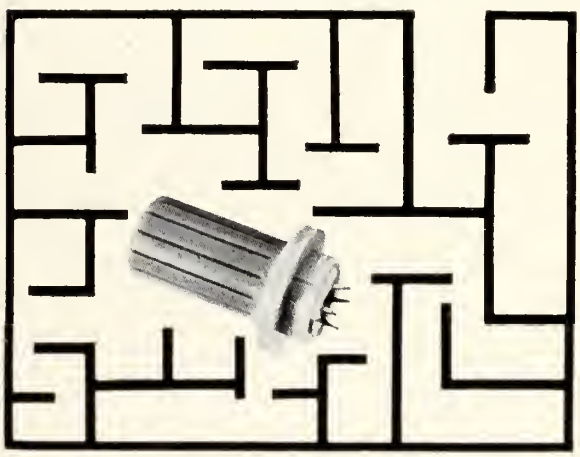
Sponsors of Riker Service—
the complimentary classified service for physicians.

The Pill Vs. Pregnancy

In the midst of the controversy over oral contraceptives, commenting on the findings of the Food and Drug Administration's Advisory Committee on Obstetrics and Gynecology, Syntex Laboratories of Palo Alto, California, suggests that emphasis is being put in the wrong place.

While there is a demonstrated increased risk of thromboembolic phenomena in oral contraceptive users, with four to seven times the risk of death due to embolisms as non-users, the fact remains that the risks are extremely slight—1.5 deaths per 100,000 in a woman 20 to 34 years of age, 3.9 per 100,000 in a woman 35 to 44.

The risk of death associated with pregnancy is 17 times that associated with pill taking, according to British findings, already released.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST

(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

473-9

The Doctors Carl A. Grote of Huntsville

(Continued from Page 333)

About the time the Titanic plunged to its doom in the North Atlantic and a gay world was singing a song hit of the century, "Waiting for the Robert E. Lee," the first full-time health officer in Alabama medical history was assuming his duties in the coal-mining, cotton-milling town of Jasper, in Walker County.

Born in Greensboro on Wednesday, April 20, 1881, Carl August Grote completed his liberal arts education in his home town, graduating from Southern University with an A. B. degree in 1907, and earning his M. D. degree from the University of Alabama Medical School, Mobile, five years after that.

Dr. Grote (which is properly pronounced in two syllables) moved from Jasper to Huntsville just when his country entered World War I as Madison County health officer, and except for a 12-month interlude in Greensboro, N. C., 1923-24, would make that city his home for the rest of his life. He returned to Huntsville in 1924 to enter private practice.

It was in Huntsville that his son, Carl A. Grote, Jr., was born Oct. 19, 1928. After attending Columbia Military Academy in Tennessee, receiving his baccalaureate and M. D. degrees from Vanderbilt, interning in Grand Rapids, Mich., and, after a two-year tour in the Medical Corps, serving a residency in the Huey P. Long Hospital, Pineville, La., the junior Dr. Grote returned to his native Huntsville in July, 1958, to join his father in private practice.

Dr. Grote, Sr., a past President of the Medical Association of the State of Alabama (1947), a delegate to A. M. A. for two separate terms, on the board of Blue Cross-Blue Shield at the time of its founding, a past President of the Huntsville Kiwanis Club, was chosen Citizen of the Year 1964 by the Alabama State Chamber of Commerce.

Like father, like son, recognition has come to Dr. Carl Grote, Jr., elected to the College of Counsellors in 1966. He is a past president, Tennessee Valley Chapter, AAGP; past president, Madison County Medical Society; president-elect, Alabama Chapter, AAGP; editor, Alabama Family Physician; immediate past chairman of MASA's Committee on Public Relations. Dr. Grote, Jr., is the newest addition to the ALAPAC Board of Directors, appointed to fill a vacancy in the 8th Congressional District.



Dr. Grote, Sr.



Dr. Grote, Jr..

Medical College Pay-Scale Rise

How valid is the charge of "academic inflation" made against faculties in the nation's medical schools? A survey conducted by the Association of American Medical Colleges points out that the validity test must be based on two assumptions: (1) that salary levels at the beginning of the period (1964) were competitive and in equilibrium with the economy at that time; and (2) that the subsequent rise has been out of proportion to the increases in parallel or competitive salary systems.

On this premise, the results of the AAMC survey flatly contradicts the charge of "academic inflation," pointing out that:

"During this period (1964-1969) the gross national product increased from $632 billion to $850 billion (34 per cent). The consumer price index rose 12 per cent. In general, medical faculty salaries rose 32 per cent. All medical costs rose 30 per cent. Hospital costs rose 185 per cent. Medical fees rose 32 per cent."

(Rewritten from New York State Journal of Medicine)



introducing alginates to antacids

for a difference in taste you can feel

Derived from seaweed, and long used to impart velvety consistency to foods, alginates—a Warner-Chilcott contribution to antacid palatability—help 1) erase the chalkiness and grittiness found with some other antacids; 2) dispel unpleasant aftertaste. Like ice cream, Gelusil-M is smooth and creamy; and it has a cool mint flavor. Thus, for your patients Gelusil-M is excellent to start on and easy to stay on.

introducing

GELUSIL®-M

NEW

each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate
250 mg. aluminum hydroxide (Warner-Chilcott)
200 mg. magnesium hydroxide

*U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

†Avoids constipation.

See next page for prescribing information ▶

GELUSIL–one name to remember...and a dosage form for every patient.



Gelusil®-M Liquid

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquid

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)—or more—between meals and at bedtime, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey
GM-IN-91-4C



The Month in Washington

From the Washington Office
American Medical Association

Washington, D. C.—A Food and Drug Administration advisory committee found oral contraceptives to be "safe," but reported that British and U. S. studies had established "an etiologic relation between thromboembolic disorders" and their use.

The Advisory Committee on Obstetrics and Gynecology, making its second report on oral contraceptives, said that their benefits outweighed the risks sufficiently to designate them "safe" within the intent of the federal law.

As for the potential carcinogenity of oral contraceptives, the report said no conclusion could be drawn at this time.

The committee called for intensive research along three lines: 1) possible relationship of hormonal contraceptives and carcinoma of the breast and uterus; 2) determination of the basis and prognosis of metabolic alterations produced by hormonal contraceptives; and 3) development of new methods of contraception.

The committee, in its initial report three years ago, approved of oral contraceptives with reservations. It now said that these reservations appear to have been justified because of the adverse reactions reported in both scientific literature and the general press. But the report concluded:

"When these potential hazards and the value of the drugs are balanced, the committee finds the ratio of benefit to risk sufficiently high to justify the designation safe within the intent of the legislation (Kefauver-Harris Amendments of 1962)."

The report said scientific studies "suggest that the mortality from thromboembolic disorders attributable to the oral contraceptives is about three per 100,000 women per year, adding less than three per cent to the total age-specific mortality in users of these drugs." In a U. S. study, the risk of thromboemoblism to a woman using hormonal contraceptives was estimated by indirect methods to be 4.4 times that of a non-user.

The report said there is no evidence that any metabolic alterations induced by the oral contraceptives pose serious health hazards.

The effectiveness of oral contraceptives was found to be significantly higher than for intrauterine devices or traditional methods.

* * *

Abandoning a long court fight, the Internal Revenue Service reversed itself and ruled that organizations of physicians authorized under state professional association laws will be treated as corporations for tax purposes.

The IRS announced that it would not appeal to the Supreme Court two recent decisions by U. S. courts of appeal favoring the professional association. In accordance with these court decisions, the IRS said, "organizations of doctors, lawyers and other professional people organized under state professional association acts will, generally, be treated as corporations for tax purposes."

Forty-two states have such laws which offer tax benefits, including deferment of the tax on pension plan contributions until retirement.

The court controversy over IRS treatment of the professional associations for tax purposes dated back to the early 1950's. It was given a "Kintner" label in 1954 when an appeals court ruled in favor of the professionals

(Continued on Page 341)

The AMBAR® SCRAPBOOK of

Obesity Oddities

FACT & LEGEND

OBESITY WAS A MILITARY OFFENSE!

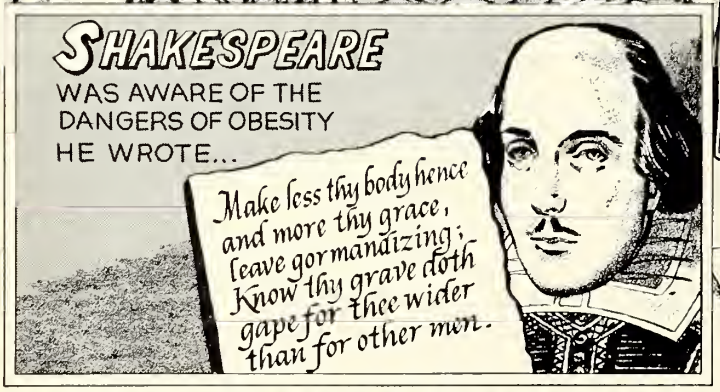
OVERWEIGHT ROMAN HORSEMEN WERE MADE TO FORFEIT THEIR MOUNTS AND BECOME FOOT SOLDIERS!

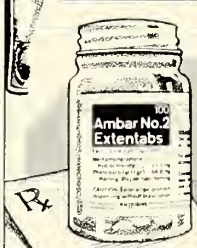


RECORDED ON AN ENGLISHMAN'S TOMBSTONE

SHAKESPEARE

WAS AWARE OF THE DANGERS OF OBESITY HE WROTE...





THE COST OF **AMBAR EXTENTABS** IS APPROXIMATELY ONE HALF THAT OF OTHER LEADING APPETITE SUPPRESSANTS

AN IMPORTANT FACTOR IN LONG TERM THERAPY

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS

(Continued from Page 339)

in a case brought by Arthur Kintner, M. D., Missoula, Montana.

* * *

The federal government has started a program designed to increase enrollment in the nation's schools of medicine and osteopath by 4,000 over the next four years.

Known as the Physician Augmentation Program, the activity, under the Department of Health, Education and Welfare, supports the addition of 1,000 first year places commencing with the fall term of 1970. These places are in addition to any increase to which the schools have already committed themselves. Total enrollment through this program is expected to be about 4,000 in the fourth year of operation. The Physician Augmentation Program is authorized under the Health Manpower Act of 1968.

Grants will be awarded on a national competitive basis to those schools of medicine and osteopath that document their intention to institute a major increase in their first-year enrollment and that appear to have the greatest potential for achieving major increases with their own resources as supplemented by funds allocated by the program.

* * *

Robert H. Finch, secretary of Health, Education and Welfare, proposed that state medicaid administrators work more closely with state medical societies on cost control in the federal-state health care program.

He also said that the states should review more claims in efforts to control medicaid costs.

Finch gave his views on controlling medicaid costs in a letter to Senator Abraham Ribicoff (D., Connecticut) who had asked what was being done and what additionally could be done about rising expenditures in the program.

In answer to a question as to what states "could be doing under existing law to control medicaid costs more efficiently," Finch said:

"One answer is to spend more money on the claims review function. For example, there are two states where annual medicaid expenditures are in excess of one hundred million dollars. One employs seven people for its review function, the other employs 70. The latter state has very effective control over costs and utilization.

"But I am coming to believe that a major factor is the degree to which physicians are involved in the program, not simply as purveyors of medical care but also as watchdogs of costs and guardians of quality. They generate the bulk of medicaid expenditures. They authorize admissions to hospitals and skilled nursing homes and they write prescriptions. The need for genuine physician participation in controlling costs is self-evident. A state medicaid administrator would be well advised to make extensive use of his medical advisory committee and to engineer the plan in detail through the state medical society."

As to what states already are doing, Finch said:

"Some states are using prior authorization of service (emergencies excepted). Some use fee schedules. Some use audit tolerance levels. Some incorporate parameters of medical care into their data processing systems. Some develop client and purveyor profiles. Some use computers to process claims. Others contract the review function to a fiscal agent, e. g., a Blue Cross plan. Some use a medical audit and some have been doing very little."

Ribicoff said in his letter to Finch that he understood "there is very uneven performance of medicaid program review throughout the nation."

Peer review under leadership of state and county medical societies has top priority in the American Medical Association recom-

(Continued on Page 344)

Pertofrane® desipramine hydrochloride

Coming out of a depression.

And it can often begin to happen in 3 to 5 days with an antidepressant like Pertofrane. There's a lifting of depressed mood . . . a restoration of psychomotor activity. Patien usually begin to cope, work, maybe play, even enjoy.

It's not all beautiful. Sometimes there are side effects. And not everybody can take the drug. It may even b a slow process. But along with the care and comfort you give depressed patients, consider Pertofrane. Then consider the respo

Please read the prescribing information for full details on contraindications, warnings, precautions, adverse reactions and dosage. It's summarized on the left.

Pertofrane®

desipramine hydrochloride

New 50-mg. capsules now available

Indication. Mental depression.

Contraindications. Do not use MAO inhibitors concomitantly or within 2 weeks of the use of this drug. Hyperpyretic crises or severe convulsive seizures may occur with such combinations; potentiation of adverse reactions can be serious or even fatal.

When substituting Pertofrane in patients receiving an MAO inhibitor, allow an interval of at least 14 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.

The drug is contraindicated following recent myocardial infarction and in patients with a known hypersensitivity to tricyclic antidepressants.

Warning. Activation of psychosis may occasionally be observed in schizophrenic patients. Due to atropine-like effects and sympathomimetic potentiation, use only with the greatest care in patients with narrow-angle glaucoma or urethral or ureteral spasm.

Do not use in patients with the following conditions unless the need outweighs the risk: severe coronary heart disease with EKG abnormalities, progressive heart failure, angina pectoris, paroxysmal tachycardia and active seizure disorder (may lower seizure threshold).

Desipramine and the parent compound, imipramine, have been shown to block the action of guanethidine and related adrenergic neuron-blocking agents.

Hypertensive episodes have been observed during surgery.

The concurrent use of other central nervous system drugs or alcohol may potentiate adverse effects. Since many such drugs may be used during surgery, desipramine should be discontinued prior to elective procedures.

Caution patients on the possibility of impaired ability to operate a motor vehicle or dangerous machinery.

Do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk, and do not use in patients under 12 years of age.

Because of increased sensitivity to the drug, use lower than normal dosage in adolescent and geriatric patients.

Precautions. Potentially suicidal patients require careful supervision and protective measures during therapy. Discontinuation of the drug may be necessary in the presence of increased agitation and anxiety shifting to hypomanic or manic excitement.

Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents).

Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications; transient cardiac arrhythmias have occurred in rare instances.

Periodic blood and liver studies should supplement careful clinical observations in all patients undergoing extended courses of therapy.

Adverse Reactions. The following have been reported. *Nervous System*: dizziness, drowsiness, insomnia, headache, disturbed visual accommodation, tremor, unsteadiness, tinnitus, paresthesias, changes in EEG patterns, epileptiform seizures, mild extrapyramidal activity, falling and neuromuscular incoordination. A confusional state (with such symptoms as hallucinations and disorientation), particularly in older patients and at higher dosage, may require discontinuation of the drug. *Gastrointestinal Tract*: anorexia, dryness of the mouth, nausea, epigastric distress, constipation and diarrhea. *Skin*: skin rashes (including photosensitization), perspiration and flushing sensations. *Liver*: rare cases of transient jaundice (apparently of an obstructive nature) and liver damage. If jaundice or abnormalities in liver function tests occur, discontinue the drug and investigate. *Blood Elements*: bone-marrow depression, agranulocytosis, thrombocytopenia and purpura. If these occur, discontinue the drug. Transient eosinophilia has been observed. *Cardiovascular System*: orthostatic hypotension and tachycardia. Carefully supervise patients requiring concomitant vasodilating therapy, particularly during initial phases. *Genitourinary System*: urinary frequency or retention and impotence. *Endocrine System*: occasional hormonal effects, including gynecomastia, galactorrhea and breast enlargement, and decreased libido and estrogenic effect. *Sensitivity*: urticaria and rare instances of drug fever and cross-sensitivity with imipramine.

Dosage. All patients except geriatric and adolescent: 50 mg. t.i.d. (150 mg. daily). Dosage may be increased up to 200 mg. daily. Geriatric and adolescent patients should usually be started with lower dosage (25 to 50 mg. daily) and may not tolerate higher doses. Dosage may be increased up to 100 mg. daily.

Lower maintenance dosages should be continued for at least 2 months after obtaining a satisfactory response.

Mild anxiety and agitation which may accompany depression usually remit as the depression responds. Occasionally, however, a sedative or tranquilizer may be indicated.

Availability. Maroon and pink capsules of 50 mg. in bottles of 100; pink capsules of 25 mg. in bottles of 100 and 1000. (B)46-530-G

For complete details, please see the full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

It's beautiful!



(Continued from Page 341)

mendations for controlling costs in both medicaid and medicare. A report of the AMA board of trustees approved by the house of delegates at the 1969 annual convention in New York strongly urged that:

—"Peer review be assigned the highest priority by the state and county medical societies; that where existing mechanisms exist, they be strengthened, and where they do not, they be promptly established.

—"quick and decisive action be taken, in appropriate fashion, to discipline those few physicians determined after investigation to be abusing medicare and medicaid, either fraudulently or otherwise."

The AMA recommendations for cost control in government health programs also include:

—"The promotion of innovative health service delivery systems for low income communities with emphasis on ambulatory care.

—"Programs by local medical societies to insure preservation of quality health care in the face of cost containment measures."

Books Of Interest To Doctors And Patients

AT YOUR OWN RISK: The Case Against Chiropractic, by Ralph Lee Smith, Trident Press, a division of Simon & Schuster, New York, 191 pages, cloth—$4.95; issued simultaneously by Pocket Books, Inc.—.95c.

Published last month, this devastating, well documented indictment of chiropractic, both in theory and practice, had found its way into the hands of most members of the Legislature before the regular session of that body had adjourned, presented to them by MASA.

Milton Helpern, M. D., Chief Medical Examiner of the City of New York, summarizes the subject tersely: "The teachers, research workers and practitioners of medicine reject the so-called principle on which chiropractic is based, and correctly and bluntly label it a fraud and hoax on the human race."

Some three million Americans seek out chiropractic treatment each year, hoping to be cured of backaches, headaches, cancer, diabetes, asthma, insomnia, appendicitis, pneumonia, and practically every other disease known to man, says the author of this book, adding that: "At best, most of these people walk away from their treatment with less money in their pockets. At worst, they are the victims of conditions that only become aggravated by failure to obtain timely medical treatment. In addition, they run dangerous risks from unnecessary exposure to X-rays, or from inappropriate chiropractic ministrations which, in some cases, result in crippling or paralysis and, in a few cases, death."

Actually the book opens on a California case that resulted in the death of an 8-year-old girl and the sentencing of her attending chiropractor to five years in prison on his conviction of second-degree murder.

Some of the chapter headings are a key to the book's content:—"The Iowa Grocer's Dream," "Chiropractic Today," "I Get the Treatment," "The Supersalesmen," "X Ray—the Chiropractor's Toy," "Hands of Danger and Death," and so on.

And finally there is the quote from the 1968 report of the U. S. Department of Health, Education and Welfare: "Chiropractic theory and Practice are not based upon the body of basic knowledge related to health, disease and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment."

—W. J. Mahoney, Jr.

Alabama Department of Public Health

Health Education Curriculum Development Workshop

By Catherine Lamar

The first health education curriculum development workshop for grades kindergarten through 12 in this state was successfully concluded June 27 at the University of Alabama campus in Tuscaloosa.

The three-week workshop was designed to assemble leaders to develop and implement curriculum reforms in health education for these grades throughout the state. Fifty-five selected educators and community health personnel and 20 resource people and consultants registered for the program sponsored by the Department of Health, Physical Education, and Recreation of the University of Alabama in cooperation with and support from leading state educational and health agencies and organizations.

This project was an outgrowth of the National Conference on Curriculum Development in Health Education held three years ago in Washington, D. C. Alabama's delegation returned determined to organize a similar project for this state.

When a project grant application for Title I funds was rejected, the committee launched a campaign to enlist support from official, volunteer, and private health agencies and groups. Over $10,000 was raised in this manner to support the venture.

Concurrently with the financial campaign, a survey was developed to establish a foundation for curriculum development. Seven hundred copies of the survey were dis-



Working in small groups allowed in depth analysis of topical areas by grade levels. This session includes (L. to R.) Mrs. Ann R. Jordan, principal, Hall-Kent Elementary School, Hueytown; Miss J. Lanell Guyton, teacher, Health, Physical Education, and Guidance, Hueytown Elementary School; Mrs. Edna R. Bailey, school consultant, Gordo High School, Gordo, and Mrs. Patricia Geer, teacher, Arcadia Elementary School, Tuscaloosa. Pictured in the foreground are Miss Eleanor Blankenship, teacher, Health and Physical Education, Priceville High School, Priceville, and Charles Penn, teacher, Hartselle Junior High School, Hartselle.

THE BREAKUP of a business partnership, the crack-up of a marriage, the shake-up of being fired or reduced to bankruptcy... after any significant loss or severe blow to self esteem, *both* anxiety and depression almost always follow.



FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCl

For prescribing information, including indications, contraindications, warnings, precautions, and side effects, please see following page.



FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCl

TRIAVIL®2-25: Each tablet contains 2 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®4-25: Each tablet contains 4 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®2-10: Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

TRIAVIL®4-10: Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; urinary retention; pregnancy; glaucoma. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least 2 weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory response.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be potentiated.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed,as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

SIDE EFFECTS: Similar to those reported with either constituent alone.

Perphenazine: Should not be used indiscriminately. Use caution in patients with history of convulsive disorders or severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; severe acute hypotension (of particular concern in patients with mitral insufficiency or pheochromocytoma); skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); grand mal convulsions; cerebral edema; altered cerebrospinal fluid proteins; polyphagia; paradoxical excitement; photophobia; skin pigmentation; failure of ejaculation; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia; significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol), atropine, heat, and phosphorous insecticides.

Amitriptyline: Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypotension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, blurring of vision, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

For more detailed information consult your Merck Sharp and Dohme representative or see the package circular.

MSD | **MERCK SHARP & DOHME**
Division of Merck & Co. Inc. West Point Pa 19486
where today's theory is tomorrow's therapy



MEMBERS OF THE COMMITTEE FOR CURRICULUM PLANNING IN HEALTH EDUCATION pictured at the Tuscaloosa conference include (L. to R.): Forest Ludden, Public Health Executive, Alabama Department of Public Health; Dr. Bernice Finger, professor, Health, Physical Education, and Recreation, Alabama College; Dr. Willis J. Baughman, Workshop Director, profesor, Health Education, University of Alabama; Mrs. Jimmie H. Goodman, consultant, Division of Secondary Education, Alabama Department of Education; and Fred Hering, Executive Secretary, American Public Health Association, Southern Branch. Other members not pictured are Ghary Akers, consultant, Division of Elementary Education, Alabama Department of Education; Miss Miriam Collins, Alabama State Association for Health, Physical Education and Recreation; Dr. William Glidewell, professor, Health and Physical Education, Florence State University; Dr. Richard Means, professor, Health, Physical Education, and Recreation, Auburn University; and Dr. James E. Sharman, chairman, Health, Physical Education, and Recreation, Samford University.

tributed to one-third of the elementary schools and one-half of the secondary schools in Alabama. School systems in each of the 67 counties were tapped.

A return rate of 56 per cent, representative of 87 per cent of the total counties in the state, was achieved: 160, 64 per cent, of the elementary schools and 240, 52 per cent, of the secondary schools surveyed replied.

To the question "What amount of time is devoted to health instruction?" only 31 per cent of the elementary schools replied. The average for those respondents was 30 minutes a week with instruction being correlated with physical education and science classes. Almost all of the secondary schools that were queried responded that health instruction was incorporated into the physical education curriculum.

Teacher preparedness constituted another critical area of concern. In elementary schools in this state it was found that 70 per cent of the teachers providing 30 minutes or more a week of health instruction have had no course work in this subject. Eighty-three per cent of the secondary school instructors presently teaching health education had degrees in physical education in which the normal curriculum requires only six hours of health education.

One of the most dramatic results of the workshop was compilation of a preliminary draft of a health curriculum guide. This is divided into five general areas: an overview for each of the four grade levels which includes needs and maturity levels; an introduction to each of the 12 topical areas within each of the four grade levels; a list of long-range, intermediate, and immediate behavioral objectives; topical outlines; and a list of resources which includes printed materials, audiovisual aids, personnel, activities, and experiences.

The guide was developed in segments with workshop participants divided into small groups according to grade level and subject material. Some of the areas of study includ-

ed: dental health, nutrition, mental and emotional health, family life education, personal health, community and environmental health, consumer health, drugs, first aid, accident prevention, smoking, and communicable diseases. An outstanding array of national, regional, state and local experts in curriculum, methodology, instruction, child development, evaluation, and related fields assisted in each area. An attempt was made to develop a progressive and sequential ararngement of learning experiences that would permit students to follow an orderly development of knowledge, attitude, and behavior relating to health.

With completion of the preliminary curriculum guide, the project enters another important phase. Implementation will be difficult due to the lack of funds to launch a full-scale campaign of inservice training programs for teachers and a field testing program for students using the guide. A pilot project, however, has been tentatively established in the Tri-County Appalachian Project area encompassing the counties of Lawrence, Limestone, and Morgan. Teachers and school administrators who participated in the workshop have expressed their willingness to utilize the guide in their respective schools during the next year.

An immediate objective is to secure financial support for a post-workshop session to be held in the summer of 1970. Those having used the guide during the year will be asked to participate in evaluating, revising, and rewriting the guide. Hopefully, a document suitable for incorporation into school systems through Alabama will evolve.

Although the success or failure of this project is as yet uncertain, a most useful purpose has already been served. It has effectively spotlighted the need for a concerted effort to develop a strong program which will provide Alabama's school child population with the experiences, information, and practical knowledge to live healthy, productive lives.

Contributing Agencies

Alabama Dental Association

Alabama Department of Education

Alabama Department of Mental Health

Alabama Department of Public Health

Alabama Heart Association

Alabama Regional Medical Program

Alabama State Association for Health, Physical Education & Recreation

Alabama Public Health Association

Alabama Tuberculosis Association

City of Birmingham Board of Education

Health Education Section, Alabama Public Health Association

Jefferson County Association for Mental Health

Jefferson County Board of Education

Medical Association of the State of Alabama

Southern Branch, American Public Health Association

Tri-County, Appalachian Project Health Planning Commission

University of Alabama

Director of Medical Education, full-time, board-certified internist for 450 bed Medical Center needed immediately. Three full-time teaching physicians, four full-time Department Head physicians, six full-time associate physicians, contributing to medical education. Outstanding open-heart surgery program, building cardio-vascular center, outstanding urology program. $35,000 guaranteed salary, excellent benefits. Contact

R. J. WEINZETTEL, Administrator
Memorial Medical Center
63rd and Waters Avenue
Savannah, Georgia 31405
Phone 355-3200

His Specialty 'Labor Of Love' For ALAPAC Director

Toil and tennis—with tennis running a poor second!—are the hobbies filling the life of Julius Norton Hicks, M. D., of Birmingham, sixth Congressional District representative on the Board of Directors of the Alabama Medical Political Action Committee.



Dr. J. N. Hicks

Nine years the junior of his brother, James Johnston Hicks, M. D., with whom he is associated in the practice of Otology, Laryngology, and Rhinology, the AMPAC Director has been known to his intimates from childhood as "Buddy."

Earlier this year, he was the featured speaker before a meeting of the Montgomery County Medical Society, accompanying his lecture with illustrative slides.

"Buddy" Hicks was born at Enterprise, Alabama on Friday, February 1, 1929, and at the age of 20 had his A. B. degree from Duke University. Four years later, in 1953, he was endowed with the degree of M. D., accompanied by a Phi Beta Kappa key from the same school.

Between his internship at the University of Alabama (1953-54) and his residency at Massachusetts Eye and Ear Infirmary (1957-60), Dr. Hicks spent his tour of duty with the U. S. Air Force at Keesler, Biloxi, Miss.

Currently an Associate Professor, Division of Otolaryngology, Department of Surgery, University of Alabama Medical College, in charge of the Otolaryngology teaching program, Dr. Hicks is also Co-chairman, Department of Otolaryngology, Veterans Administration Hospital, and on the staffs of six Birmingham hospitals: University, Children's, Birmingham Baptist, West End Baptist, St. Vincent, and South Highlands.

A Fellow of the American College of Surgeons, his professional memberships also include the American Academy of Otolaryngology and Ophthalmology, the American Triological (Otolaryngology, Rhinology, Laryngology) Society, Birmingham Surgical Society, Birmingham Clinical Society, Birmingham Academy of Medicine, and Birmingham EENT Society.

Among the papers carrying his byline are two published in the Journal of the Medical Association of the State of Alabama: "Review Present Status Meniere's Disease" (November, 1967) and "Modern Stapes Surgery for Deafness of Otosclerosis" (December, 1960), which he co-authored with his brother and Dr. James Joseph Bushnell.

Dr. "Buddy" Hicks is married to the former Ann Barcroft of Birmingham and there are three children: Joan, 11; Jim, 9; and Barbara, 5.

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9

BUREAU OF PREVENTABLE DISEASES

Frederick S. Wolf, M. D., Director

Current Morbidity Statistics

1969

	May	June	*E.E. June
Tuberculosis	148	115	120
Syphilis	50	67	127
Gonorrhea	481	433	314
Cancroid	2	1	2
Typhoid fever	0	0	1
Salmonella	34	21	11
Undulant fever	0	0	0
Shigella	13	3	6
Amebic dysentery	0	0	3
Scarlet fever & strep. throat	475	294	77
Diphtheria	1	0	0
Whooping cough	1	2	8
Meningitis	6	3	5
Tularemia	0	0	0
Tetanus	0	1	1
Poliomyelitis	0	0	0
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	1	2	175
German measles	6	5	10
Chickenpox	25	9	38
Mumps	6	5	50
Infectious hepatitis	36	23	34
Typhus fever	0	0	0
Malaria	1	2	0
Cancer	538	548	703
Pellagra	0	0	0
Rheumatic fever	12	15	16
Rheumatic heart	18	16	27
Influenza	164	47	30
Pneumonia	370	216	215
Rabies—Human cases	0	0	0
Pos. animal heads	6	4	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

PSYCHIATRISTS OR GENERAL PRACTITIONERS

interested in psychiatry. Veterans Administration Hospital, Tuscaloosa, Alabama. Salaries to $19,900 based on training and experience. Liberal retirement plan, 30 days vacation with pay, 15 days sick leave per year, health and life insurance programs. Opportunity for physicians interested in regular hours with less demanding duties than private practice.

Write

CHIEF OF STAFF (11)

VA Hospital

Tuscaloosa, Alabama 35401

An Equal Opportunity Employer

BUREAU OF PREVENTABLE DISEASES

Frederick S. Wolf, M. D., Director

Current Morbidity Statistics

BUREAU OF LABORATORIES

1969

	July	August	*E. E. August
Tuberculosis	97	154	125
Syphilis	48	48	144
Gonorrhea	678	688	402
Chancroid	0	0	2
Typhoid fever	0	1	0
Salmonella	18	42	12
Undulant fever	0	0	1
Shigella	4	7	10
Amebic dysentery	1	0	4
Scarlet fever & strep. throat	363	351	145
Diphtheria	0	0	0
Whooping cough	7	4	8
Meningitis	5	23	7
Tularemia	0	0	0
Tetanus	1	2	1
Poliomyelitis	0	1	0
Encephalitis	2	2	0
Smallpox	0	0	0
Measles	1	0	19
German measles	1	6	3
Chickenpox	11	2	2
Mumps	4	15	17
Infectious hepatitis	25	21	39
Typhus fever	0	0	0
Malaria	0	8	0
Cancer	1,341	1,347	739
Pellagra	0	0	0
Rheumatic fever	6	10	11
Rheumatic heart	19	14	20
Influenza	28	24	18
Pneumonia	220	214	142
Rabies—Human cases	0	0	0
Pos. animal heads	5	9	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph. D., Director

June, 1969

Alabama Department of Public Health Laboratory

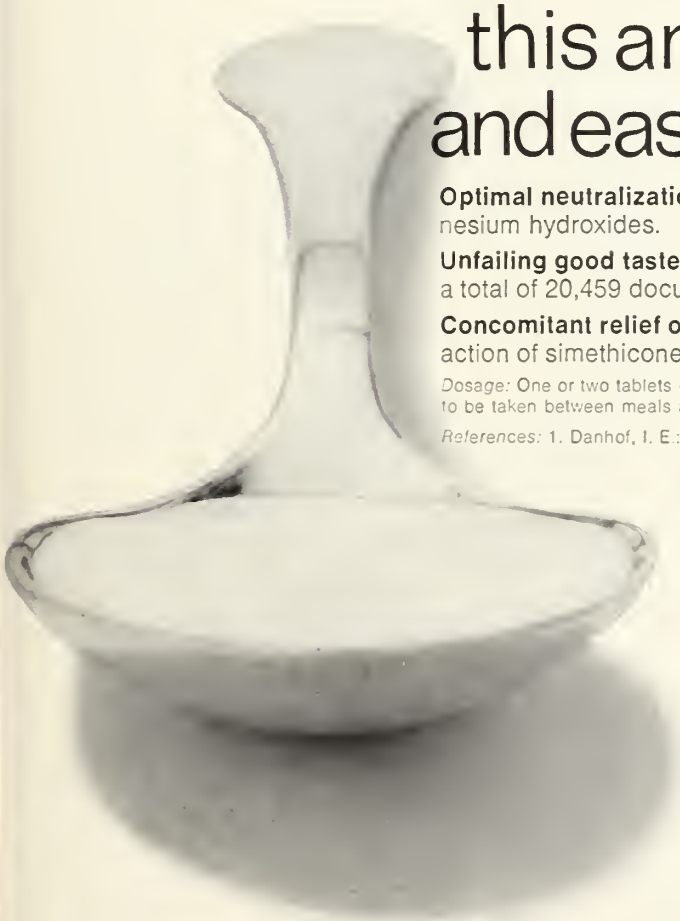
Combined* Division Report for Period

General Bacteriology	1,980
Virology	258
Parasitology	1,808
Enteric Bacteriology	409
Fluorescent Microscopy	4,481
Tuberculosis	5,026
Mycology	80
Milk and Dairy Products	5,433
Water	4,024
Sea Foods	28
Syphilis Serology	35,225
Special Serology	1,174
Metabolic Diseases	24,246
Cytology	1,371
Chemistries	216
Miscellaneous	728
Total Number of Specimens Received	86,487

* Dothan's monthly specimens report was not received in time to be included in this report.

the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization—provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste—confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[1]

Concomitant relief of G. I. gas distress—provided by the proven antiflatulent action of simethicone.[2]

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References: 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.

Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109


When mixed as directed, each 5 cc. will contain erythromycin estolate equivalent to 125 mg. erythromycin base.
Each 5 cc. contain erythromycin estolate equivalent to 250 mg. erythromycin base.
When mixed as directed, each cc. will contain erythromycin estolate equivalent to 100 mg. erythromycin base.
Each 5 cc. contain erythromycin estolate equivalent to 125 mg. erythromycin base.
Each tablet contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule® contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule contains erythromycin estolate equivalent to 250 mg. erythromycin base.
The many forms of Ilosone®
Erythromycin Estolate
Lilly
Additional information available upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.
900541

THE JOURNAL
of
THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA
Published Under the Auspices of the Board of Censors

Volume 39 October, 1969 No. 4

The Place Of Respirators In The Coronary Care Unit

D. S. Tysinger, Jr., M. D.

Dothan, Alabama

Introduction

In a coronary care unit there are four complications which may be treated with a respirator capable of delivering continuous positive pressure, intermittent positive pressure, or alternating positive and negative pressure. These four complications include acute pulmonary edema, cardiogenic shock, heart failure, and post-cardiac arrest care. In all of these complications it is important to control pH and oxygen saturations and to support blood pressure. To a great extent this can be done with a properly used respirator.

Physiology

This will be a brief review of pertinent facts. The physiology of each condition will be discussed at such time as the condition is presented.

The circulation to the lung is twofold. The arterial supply from the left heart—the bronchial artery supply—supplies all non-aerated portions of the lung including the vaso-vasorum of the pulmonary artery and all of the bronchial structures. This artery is under peripheral arterial pressure and anything that affects arterial blood pressure affects perfusion of these parts of the lung. When there is a lack of bronchial artery supply, either locally or generally, the lungs begin to lose their ability to function and, if prolonged, infarction occurs. The blood supply to the lungs is equally as important as is the blood supply to the heart and brain. Any medication intended to affect the bronchial musculature, bronchial artery or pulmonary artery must first get into the systemic circulation and be delivered by the bronchial artery to these areas. The spraying of medication on the tracheobronchial mucous membrane with direct pickup must go through the left heart and out through the bronchial artery to get to the bronchial musculature. The aerated portions of the lung are not supplied by the bronchial artery but rather by the pulmonary artery blood which becomes arterial there and supplies this area. The bronchial artery, being stretched spidery thin, is rarely able to supply both areas. Thus, when there is embolism of the pulmonary artery, there is infarction in these areas.

During the period of inspiration there is a negative pressure produced in the chest cage which augments the flow of blood in the venous system from the head, arms, abdomen, and legs into the chest. Thus, right atrial and right ventricular filling is increased during inspiration and cardiac output to the lungs from the right heart is increased during inspiration. During this time there is a slight

From the Inhalation Therapy Department and Intensive Care Unit of Flowers Hospital in Dothan.

reduction of blood flow to the left atrium and ventricle so that cardiac output to the body decreases during this inspiratory phase. On expiration, a positive pressure is developed in the chest with retardation of blood flow into the thorax from the head, arms, abdomen, and legs. With a decrease in the right heart output and increased positive pressure within the chest itself there is an increase in the flow of blood to the left atrium and thus an increased cardiac output to the body. Studies done with simple ventilation of the lungs with normal volumes of air prove that with the heart not beating and with the heart valves acting only as check valves there is a surprising amount of circulation which can be carried on through artificial ventilation alone. These studies done with radioisotopes-tagged albumen and dyes show a surprising circulatory movement by ventilation alone. In the normal individual this is of no consequence and ventilation is considered to have very little effect on circulation. This, however, is quite important in the use of respirators both in acute pulmonary edema and cardiogenic shock as well as in heart failure.

The elastic structures of the lungs are of such composition and so designed that the bronchial tubes, the alveoli with their surfactent-like substance and the interstitial tissues that fill the chest cage at full inspiration are still present in that same lung when it is completely collapsed around the hilum as in pneumothorax. All the structures appear to have elasticity and this elasticity tends always to collapse the lung. Acting against these elastic structures there is the chest cage and the diaphragm which keep the lungs at all times in a state of partial expansion. The chest cage and diaphragm produce inspiration by expanding the volume of the chest cage. This expansion acts against the elastic forces in the bronchial tubes and alveoli which are forces acting to collapse the bronchial tubes and alveoli. This pull to expand by the chest cage and diaphragm on the interstitial tissue which is opposed by the alveolar and bronchial structures causes a pull in both directions, the resultant being a more negative pressure on the interstitial tissues than that in the alveoli. As this occurs there is in turn a negative pressure produced in the alveoli. On the relaxation of the chest cage and diaphragm as expiration begins the elasticity of the alveoli and bronchial tubes are again pitted against rigidity of the chest cage and diaphragm so that in the interstitial area there continues to be a more negative pressure which keeps the pulmonary capillary bed open during both inspiration and expiration. The negative pressure attributed to the pleural space actually occurs in the pulmonary capillary bed area as a result of these two opposing forces.

As inspiration begins the bronchial tubes elongate and dilate, the alveoli get larger, and the alveolar area becomes negative in relation to the mouth (ambient area around the patient). This causes a flow of air from the ambient area outside through the oronasal passages into the lungs. As this negative pressure is dissipated by the inflowing air the pressure in the alveoli rises to zero. Then, on expiration, the pressure in the alveolar area is elevated causing the flow of air from the alveoli back out through the mouth.

Respirators

As has been pointed out in previous articles, particularly "Respirator-Patient Relations" and "The Art of IPPB," (which are obtainable from the State Medical Journal Office), an attempt was made to point out the differences between types of respirators and what they do to and for the patient. A brief review of a few of these factors seems pertinent at this point. The flow of air, oxygen or other gas from the mouth to the alveoli depends on tube length, tube diameter, pressure difference, and the rate at which this pressure difference is developed. Not the least in importance is the rate at which this pressure difference is developed. Flow rate becomes of utmost importance since high flow rates cause turbulence. Turbulence in the upper airway will tend to decrease effective tubular size and increase resistance of air flow from the mouth to the alveoli. As this occurs the

breathing effort is increased which produces greater negative pressure at the alveolar level and thereby gives a greater pressure difference which usually is produced at a more rapid flow rate and which further increases turbulence and decreases effective air flow. It should be pointed out at this time that the effectiveness of the volume cycle respirator lies in the fact that it is an extremely low flow rate machine and that it is really flow rate matched with cycling pressure that determines effective ventilation. From personal tests conducted by the author it has been proven that a pressure cycle respirator, if set at the same flow rate produced by the volume cycle respirator, will ventilate equally as well. With pressure and flow rate being the same, volume exchange must therefore be the same. There is one difference. Volume cycle respirators usually are not patient-following. The factor that confuses most physicians appears to be the fact that there are extremely few respirators on the market in the pressure cycle field—even flow rate controlled—that can produce sufficiently low flows to equal the volume cycle respirator. Therefore, the pressure cycle respirators, in general, are not as effective as volume cycle respirators because, even with cycling pressures equalized, the low flow rates obtainable with a volume cycle respirator cannot be approached with most of these respirators.

In the coronary care unit, the biggest problem from the pulmonary viewpoint will be that of an apprehensive patient who needs respiratory support for one of the reasons we will discuss later. In such instances, if a volume cycle respirator is to be used, the patient must be paralyzed with a curare-like drug. The paralyzed patient has extreme blockage to blood flow during ventilation which would potentiate shock. Also, the paralyzed patient being continuously ventilated produces high levels of antidiuretic hormone. Neither of these effects is wanted when treating patients in a coronary care unit. If a volume-cycled respirator is not to be used then one must consider control of the patient with a pressure cycle respirator that is capable of delivering sufficiently low flow rates and sufficient pressures to equal the volume-cycled respirator. Most pressure-cycled respirators cause upper airway turbulence, thus causing the patient to produce greater alveolar negative pressure which, instead of being helpful, can be lethal to the patient in acute pulmonary edema and can aggravate the patient in heart failure and the patient in cardiogenic shock. The volume-cycled respirators on the market today (with only one or two exceptions) at the most do not, and cannot, produce sufficient humidity to 100 per cent humidify the air flow through them at room temperature, much less at body temperature. Not all respirators available on the market can produce extremely low flow rates while the nebulizer is in use nor can they provide variable pressures sufficient to ventilate effectively.

Cardiogenic Shock

The first condition to be discussed is that of cardiogenic shock. This is one of the most lethal of the cardiac complications encountered. Since there are several varieties we will talk first of cardiogenic shock in which there is low central venous pressure, absent pulmonary edema and a cardiac output that is insufficient. This type of situation may be seen where there is peripheral sequestration of blood. Second is shock in which there is right ventricular involvement from a posterior infarction with ineffective right ventricular output. In this situation the central venous pressure is actually high but the lungs are quite dry. In these situations our problem is one of blood supply to the right side of the heart, which is inadequate to provide for sufficient output through the lungs to the left heart. The left heart may be capable of functioning adequately. As this situation develops there is reduction of blood supply to the organs with a build up of the metabolic acids and a metabolic acidosis. So, we would expect in this instance to see the pH trend downward to, or below 7. The CO_2 will go up in this situation. Since there is insufficient blood supply to the left heart from the

right heart and since there is an effort to keep up left heart output, the blood flows from the pulmonary artery to the pulmonary vein through preferential channels, thus bypassing the capillary bed. This produces a pulmonary A-V shunt with inadequate oxygenation of the blood so the PO_2 would also be low. The need is to increase right heart output and to increase oxygenation of the blood and to keep the air adequately humidified in the process. In this situation we need both a positive and negative phase to the respirator. Since respiration is usually one-third inspiration and two-thirds expiration, we use a positive pressure inspiration and a negative pressure expiration. By so doing we increase the intrathoracic negative pressure during the prolonged expiratory phase, (twice the duration of inspiration), to augment the flow of blood from the head, arms, abdomen, and legs. Then, during inspiration we increase the pressure which forces blood that has been siphoned into the chest cage out to the left ventricle. This will increase cardiac output and may increase it sufficiently to bring the patient out of shock. The other supportive measures usually used in these situations should be used also; this is not a replacement. Carbon dioxide is blown off which, in itself, helps to correct the blood pH. In these instances ventilation should be with oxygen, thereby increasing the oxygen saturation which rarely can be increased to normal. The oxygen must be adequately humidified. Most of the pulmonary changes attributed to oxygen poisoning are due to ventilation with dry gas. Dry gas should never be used even in anesthesia. The only signs of oxygen poisoning in the lungs that cannot be prevented by adequate humidity are lymph stasis and paralysis of the cilliary-mucous esculator. Using oxygen increases oxygen available through the coronaries to the heart itself, the bronchial arteries and lungs, and to the rest of the body, particularly to the brain and liver. By the use of positive and negative phase respiration, (with positive pressure up to 20 cm. of water; negative pressure, usually 3-5 cm. of water) and with extremely low flow rate machine that can be accurately controlled we (1) increase cardiac output (2) help to correct the acidosis developed (3) increase arterial oxygen saturation which gives support to the tissues themselves which helps the patient correct the situation.

The Patient with Pulmonary Edema

In acute pulmonary edema with or without shock, as a rule, central venous pressure is high. Due to the proteinaceous foamy material in the tracheobronchial tree oxygen saturation is poor, pH is on the acid side approaching seven, and we have a situation in which the problem is one of adequate venous return, adequate right heart output with poor left heart output. Thus, there is an increase in left ventricular and left atrial pressure followed by an increase in pulmonary venous pressure back through to the capillary bed. This causes vasoconstriction at the pulmonary arteriolar level with elevation of pulmonary artery pressure followed by high right ventricular endiastolic pressure and elevation of right atrial and central venous pressure. This continues to rise to the point that hydrostatic pressure overcomes tissue and osmotic pressure at the capillary level and fluid can no longer be contained in the vascular system. There is an egress of fluid, first into the tissues with interstitial edema, then into the alveolar spaces and into the tracheobronchial tree. This proteinaceous material becomes bubbly and foamy, thus interfering with oxygenation. Poor metabolism results with elevation of CO_2. The reduction in arterial oxygen saturation with the extremely heavy ventilatory activity that results produces a metabolic and respiratory acidosis.

In this situation the IPPB machine is run on oxygen and is used to retard thoracic filling and to control and retard right heart output. Here, humidity is of utmost importance. If dry gas is delivered to the fluid as one has with a simple oxygen bubble bottle humidifiers, the secretions become more tenacious. Moisture from the secretions is transferred

to the dry gas thereby further drying the secretions. Likewise, as was pointed out in "The Art of IPPB," side arm nebulizers do not put sufficient moisture into the gas during the inspiratory phase to humidify the gas going to the patient. This, like oxygen from simple bubble jars, is contraindicated. The use of the glycerin particle boosters is also condemned because glycerin is a water absorber and cuts down on humidity and will likewise tend to further thicken secretions. This is the last thing that is wanted. Therefore a respirator, to produce results, must be main stream nebulized as well as being able to produce very low flow rates. A respirator that will not ventilate a small cat has flow rates too high for a coronary care unit. Conventional methods of treatment consist of phlebotomy and rotating tourniquets. These are attempts at reducing venous return to the thoracic cavity. With the use of continuous positive pressure at 20-25 cm. of water on inspiration and with a retard cap on the exhalation valve so that the pressure on expiration is between 8-10 cm. of water, there is a continuous positive pressure produced within the thoracic cavity. This occurs through both inspiration and expiration retarding venous filling of the right heart. This retards right heart output into the lungs and thus, the fluid going to the left heart.

The heart follows the Law of Starling with the heart dilating with each input until there is increased volume to such a point that the heart becomes too big to respond. At this point it follows the physiologic Law of Leplace and with increase in volume there is a decrease in cardiac output. The continuous positive pressure tends to help the left heart with its output since the decreased input reduces volume and the continuous positive pressure increases output. The left heart slowly reduces in size until it finally begins to follow again the Law of Starling with increased output and the regaining of efficiency. By using continuous inspiratory and expiratory positive pressure, we reduce right heart filling, increase left heart efficiency and reverse the situation that produced the sequestration of fluid in the lungs with high pulmonary venous and capillary pressure and pulmonary edema. At the same time we put 70 per cent alcohol in the nebulizers. By nebulizing 70 per cent alcohol with appropriate IPPB equipment that will deliver it, we are able to break down the bubbly proteinaceous material by reducing surface tension. This helps clear the airways so air can be delivered to the alveolar level. By using oxygen we increase the diffusion of oxygen into the blood stream. Any increase in arterial oxygen levels improves cardiac efficiency. The high oxygen partial pressure improves delivery through the edematous proteinaceous material. The respirator thus used decreases right heart output and reverses the changes of acute pulmonary edema much more satisfactorily and much quicker than can be done with phlebotomy or rotating tourniquets. These may be used along with continuous inspiratory and expiratory positive pressure. When using this technique the patient must be watched closely. As soon as the lungs become reasonably dry the IPPB should be stopped since at this point it begins to retard both right and left heart output and can reduce output. The patient should be checked frequently. At any sign of recurrent pulmonary edema he should be put back on the respirator until this is reversed. The patient is watched and this is repeated until the patient no longer is having trouble.

The Use of Respirators in Postcardiac Arrest

In cardiac arrest the problems are (1) lack of circulation and oxygenation with a rapidly developing metabolic acidosis. In the brain, as this develops, there develops cerebral edema. The most highly recommended method of treatment involves raising the pH to about 7.5, keeping the patient alkalotic at this level, and giving the patient high oxygen concentrations. Both of these maneuvers cause cerebral vasoconstriction with adequate oxygenation which in turn tends to reduce cerebral edema and return the brain to normal. With hyperventilation,

CO_2 levels are reduced which also adds to the cerebral vasoconstriction and reduction of cerebral volume. Therefore, in acute cerebral edema occurring with and following acute cardiac arrest, hyperventilation with a respirator for three to five days will help. It is necessary to monitor pH closely while hyperventilating the patient. With high oxygen intake, oxygen must be completely humidified. The pH should be maintained at about 7.5 with high oxygen levels, thus counteracting the vasodilatation. After several days the pH is slowly reduced to normal after which the patient is taken off of a respirator.

The Use of the Respirator in Heart Failure

In heart failure there is a failure of the left heart to keep up with the output of the right heart, similar to acute pulmonary edema, with the sequestration of fluid in the lungs. The use of the respirator is to reverse this pulmonary sequestration with left ventricular support by the periodic use of intermittent positive pressure with appropriate equipment. By using the respirator periodically as required by the patient there is support to keep the cardiac size small and to help redistribute fluid from the lungs to the peripheral circulation, thus helping maintain cardiac efficiency.

Precautions

In the patient with moderately severe to severe chronic obstructive lung disease negative phase should be used with extreme caution as this may cause trapping and make the condition worse, or even be lethal.

In the patient with elevated CO_2 with the respirator driven by oxygen, the pH, PO_2, and PCO_2 should be monitored at least every 15 minutes following the taking of the patient off the machine. The high oxygen pressures may cause apnea with very rapid rises in PCO_2 and drops in pH and PO_2 with coma and death.

Where there is a chance of oxygen apnea, the respirator should be driven by compressed air.

In the patient with restrictive pulmonary disease who has elevated PCO_2 the machine may cause extremely high oxygen levels. This can occur even when the machine is driven by air-oxygen mixtures. This occurs because the rate of increase of pressure throws the venturi off. Oxygen injection continues and air is not sucked in so that oxygen levels rise. Since air-oxygen mixtures are venturi controlled, they do not work in restrictive disease and thus deliver unpredictably high oxygen levels. In this situation the respirator should be driven by compressed air.

Summary

The use of a respirator, and the restrictions as to type of respirator and precautions that should be used, has been discussed. The different situations in which a respirator can be of immense help and pertinent physiology relating to same has been presented. For complete coverage, it is suggested that the patient read the complete list of articles on these subjects: "Oxygen-Patient Relations," "Respirator Patient Relation," or "CO_2 Patient Relation," "The Approach and Treatment of Acute Respiratory Acidosis," "An Approach to Treatment of Chronic Lung Disease," "The Art of IPPB," all of which are obtainable from the State Medical Journal Office.

If Life Is Prolonged, Make It Enjoyable

By

Ferdinand F. Schwartz, A. B., B. S., M. D., F. I. C. A.,

A. A. P. M. R., M. R. S. H.*

What will be the story of the family of man across the near or far future? Often the faces speak what words can never say.[1]

—Carl Sandburg

The middle of the twentieth century began to reveal the entry of an entirely new generation into our lives, namely the champions of longevity above the age of 65. Life span has been increased greatly but has society furnished the enjoyments and independency to enjoy the prolonged life? By 1980 it is estimated that there will be 22 millions of people above the age of 65[2] and our nursing homes will have to assume the responsibilities of taking care of as many as possible of the chronically ill and rehabilitate them to useful life as far as their need and capacity demand. Physicians, nurses, spiritual leaders and all the ancillary forces must be mobilized to achieve the results thru early and intensive care. Modern nursing homes are a haven for the homeless, hemiplegics, arthritics, neurological disorders, post traumatic cases, mental and physical weakness and circulatory disturbances. Facilities must be provided for reconditioning these patients rather than allowing them to vegetate thru inactivity and frustration which may eventually result in moral, mental, physical and emotional decadence.

Consultation services, especially in metropolitan areas where specialists are available, should be part of the routine management of the elderly in order to prevent contractures, muscle spasm, decubitus ulcers atrophy of disuse, circulatory stasis, edema, mental confusions, emotional trauma and permanent bed or wheelchair occupancy. Krusen[3] well expressed it in his writing, "rehabilitation should be everybody's interest but it cannot be everybody's business."

Walking thru beautiful edifices one's eyes may meet an elderly patient with a superficial and sardonic smile, with a seemingly calm composure even though he is torn within by the pain of loneliness. Others may be confined to the four walls of a neat room, who were fathers and mothers enjoying the leadership of their homes in the past, and now the only rewards for the past glories are neglect, inactivity and vegetation. The desire to live and enjoy the fruits of their lives are stunted by the indifference to their needs. The brain commences to set in a concrete of desolation thus destroying motivation for the remaining few years which might be an assignment for a long and arduous labor of existence. Bitterness masks the once loving heart. The helplessness of age thru repeated frustrations becomes the bastion of a small circumscribed world of complete resignation. Their ambition is minute, they only fight for recognition and acceptance of the non-plus relatives and friends. They wish to be once again the man, the person who was accepted by their fellow men with love instead of with pity during their productive years. They seek peace of mind instead of hostilities from an over strained generation. They want to get out of bed, walk around, touch familiar objects and be free of the shackles of infirmity. As one of my old patients remarked, "doctor, I would like to renew my acquaintance with the ground instead of lying in bed for months."

* Associate Clinical Professor of Physical Medicine and Rehabilitation, Medical College of Alabama, Birmingham, Alabama; Medical Director of the Birmingham Institute of Physical Medicine and Rehabilitation.

The need for understanding the future outlook of our geriatric patients is of a paramount importance. Conditioning facilities, proper medications, good nursing care, well balanced diets, recreational therapy, physical and occupational therapy, socialization, and spiritual facilities under good medical supervision are the answers which must be prescribed for the restoration to maximum independence in order to enjoy a painless and enjoyable life whenever it is possible. If the general condition of a patient is improved, whether he is a hemiplegic or an arthritic, the outlook for him becomes more hopeful and brighter. Hippocrates said, "life is motion."

A small department of physical therapy and rehabilitation under the supervision of a physician who is either trained or acquainted with the specialty, is a useful adjunct in the management and treatment of the chronically ill in a modern nursing home. The treatments with physical agents and exercises must be just as meticulously prescribed as any form of medication in order to obtain the best and most beneficial results in the geriatric patients. In the old hemiplegics, transfer from bed to a wheelchair, transfer from a wheelchair back to bed, self care, and in some instances gait training, crutch walking must be taught. Properly prescribed exercises will prevent muscle atrophy and contractures. Proper bed, sitting and standing postures will relieve stress and strain on the joints and muscles. Pulley exercises will loosen joints and relieve pain which is due to inactivity. Heat in its various forms, such as short wave, moist heat pads, infra red, paraffin bath and whirlpool bath will increase circulation and decrease muscle spasm. In heat therapy contraindications must be adhered to. Ultrasound and low voltage therapy may benefit joint involvements. Hydrotherapy is a useful adjunct in the treatment of neurological and peripheral vascular diseases but the temperature of the water and duration of the treatments must be precisely prescribed. Ultra violet therapy may be helpful thru its tonic effect. Decubitus ulcers are more easily prevented than cured. If they occur, heat lamp and ultrasound therapy may be beneficial. Orthopedic appliances may occasionally be prescribed for ambulation and posture. Special attention must be paid to good fitting shoes and socks to insure comfort. Occupational therapy should be either diversified or functional to teach fine and coordinating motions.

Bibliography

1. Sandburg, C.: The family of man—prologue to the photographic exhibit at the New York Museum of Art.—Jan. 1955.

2. Krusen, F. H.: Rehabilitation of the aging. South. Med. J., 53:1375—1960.

3. Report and Guidelines: Recreation, White House Conference on Aging, US Dep't. of Health, Education and Welfare, Washington, D. C., Apr. 1961, pg. 1.

4. Schwartz, F. F.: Physical Medicine in Private Practice. Medical Times, Jan. 1956.

5. Schwartz, F. F.: Care of the Handicapped, Pan American Woman's Journal, Vol. 59, No. 3, March, 1952.

6. Schwartz, F. F.: Physical Medicine and Rehabilitation in Arthritis. J. Med. Assoc. of Alabama, Jan. 1956.

7. Schwartz, F. F.: Indication and Contraindication in Ultrasonic Therapy. South. Med. J., 47:854-858, Sept. 1954.

8. Schwartz, F. F.: Physical Medicine and Rehabilitation in Chronic Illness, J. Med. Assoc. of Alabama, 28:10-12, July 1958.



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

Pro-Banthine® Helps...

propantheline bromide

...REVEAL the ulcer

...HEAL the ulcer

The efficiency of Pro-Banthine—its favorable balance of therapeutic and secondary actions—has been thoroughly tested and observed. This quality has been demonstrated surgically, roentgenographically, cinegastroscopically and, above all, clinically.

When physicians needed to relax the restless duodenum for the recently refined technic of hypotonic duodenography they logically turned to Pro-Banthine.

For years Pro-Banthine has been the most widely used anticholinergic medication for calming the gastrointestinal tract—for suppressing secretion, prolonging the action of antacids and providing the proper environment for healing peptic ulcers.

These established therapeutic actions make Pro-Banthine particularly useful in:

- peptic ulcer
- gastritis
- diverticulitis
- irritable colon
- biliary dyskinesia
- functional hypermotility

We wish to thank Drs. Marcia K. Bilbao, Louis H. Frische, Josef Rösch and Charles T. Dotter for this exceptionally graphic example of hypotonic duodenography.

Contraindications: Glaucoma, severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly men with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

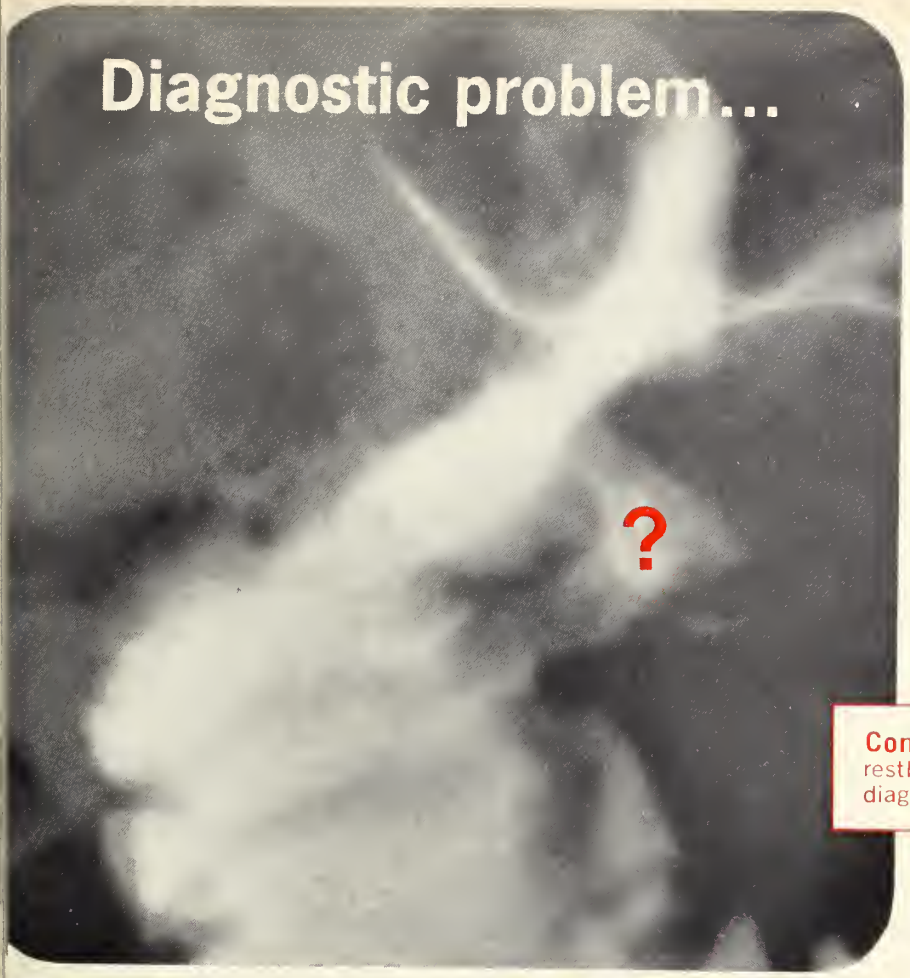
Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal dosage tolerated without excessive side effects is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two 15-mg. tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

982

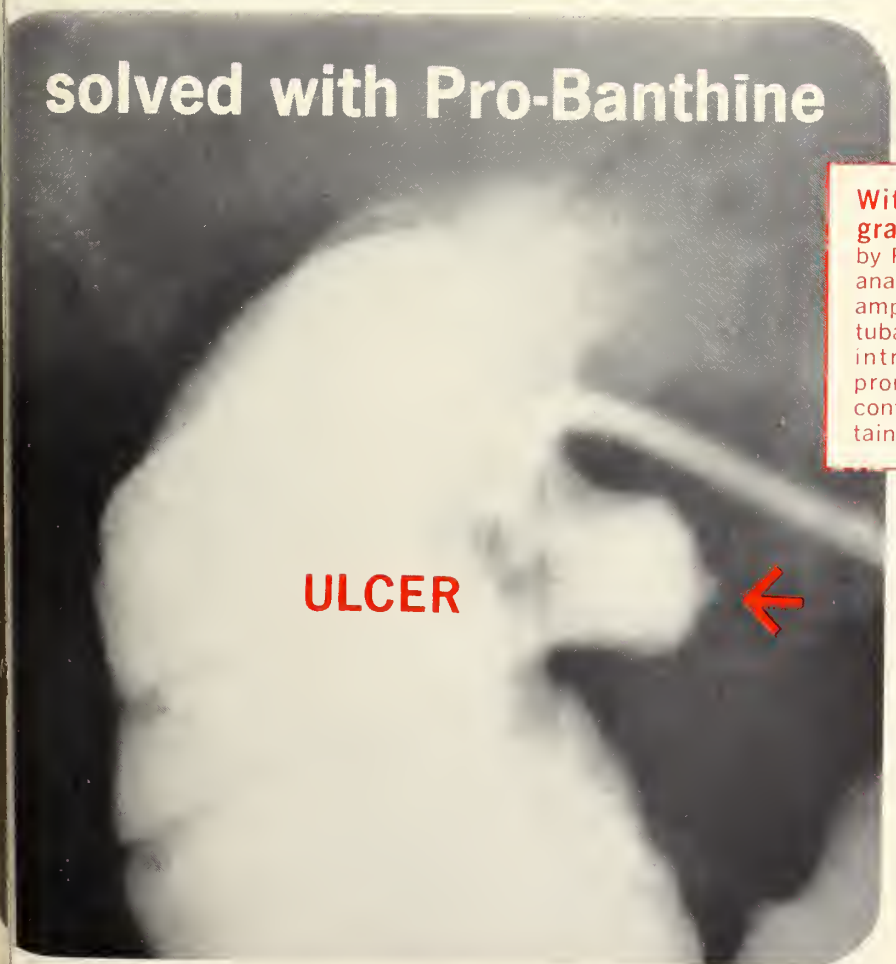
SEARLE *Research in the Service of Medicine*

Diagnostic problem...



Conventional x-rays of the restless duodenum are often diagnostically indefinite.

solved with Pro-Banthine



With hypotonic duodenography duodenal calm induced by Pro-Banthine permits clear anatomic appraisal. In this example the duodenum was intubated. Pro-Banthine, 60 mg. intramuscularly, produced prompt aperistalsis. Double contrast visualization was obtained with barium and air.

What's Polycillin® (ampicillin trihydrate) got to do with the price of bananas?

Just this: According to the U.S. Bureau of Labor Statistics, bananas are one of the few things that actually cost less today than five years ago. The same is true of Polycillin. In fact, the price of Polycillin has been reduced about 30% since its introduction in 1963...making it, according to national surveys of patient costs, as economical as leading brands of tetracycline and erythromycin.

And Polycillin is available in a variety of dosage forms for your patients—more than any other ampicillin. It comes in 250 mg. and 500 mg. capsules; in convenient, chewable tablets of 125 mg; oral suspension, 125 mg. and 250 mg. per 5 ml.; and in pediatric drops, 100 mg. per ml. Also available parenterally as Polycillin-N (sodium ampicillin).

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201





Review of Legislative Developments Relating To Health and Medicine

Laws are rules of conduct made by civilized men to protect the weak from the strong, someone has said. The 1969 Regular Session of the Alabama Legislature had more than 200 health-related measures introduced designed to protect the health and safety of the people of Alabama. Among these were the following bills:

The Title XIX (Medicaid) Program in Alabama was launched by the Legislature with the passage of House Bills 281, 282, and 283. The bills levy respectivly a 5 per cent whiskey tax increase, a one cent per package cigarette tax increase and a one cent per can additional tax on beer. These new taxes will provide approximately $12 million for fiscal 1970 and $17 million for fiscal 1971. Many health planners feel these amounts will be inadequate for Alabama's modest Medicaid program.

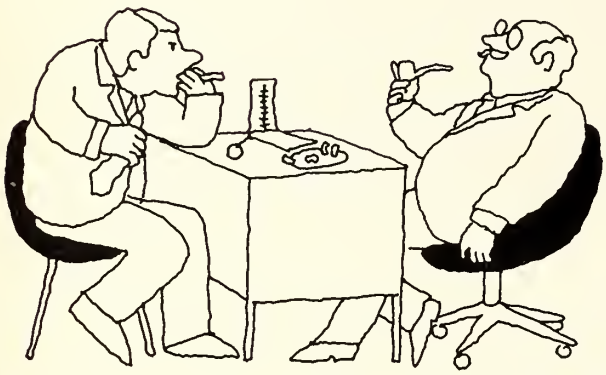
The Legislature, on the last day of the session, took the first step in establishing an an air pollution control program. S. B. 520 (same as H. 832) provides for a 12-man air pollution control commission including four physicians. The Health Department is established as the agency responsible for administering the law. S. B.s 521 through 526 provide tax incentives for industry to purchase and install air pollution control devices. S. B. 520, while not utopian, is a good beginning in coping with the air pollution problem in Alabama.

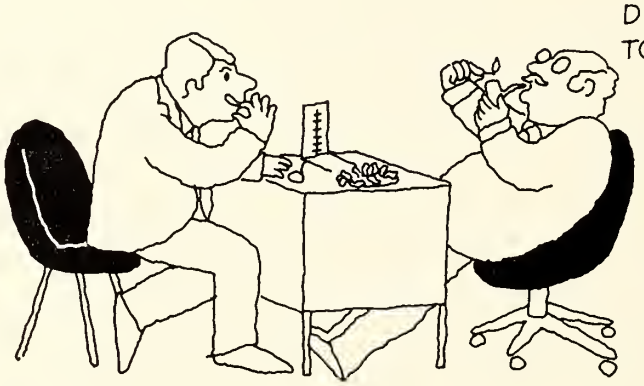
Highway Safety proponents were elated over passage of S. B. 70, providing for the use of chemical tests by implied consent to determine vehicle operator intoxication. This measure was introduced by Sen. Tom Radney of Tallapoosa County. Rep. John Blanton introduced numerous similar implied consent measures in the House—all to no avail—as Speaker Fite consigned each one to his Highway Safety (graveyard) Committee.

A bill necessary for compliance with Medicare (Title XIX) provisions was passed. S. B. 77, establishes a mechanism for licensing nursing home administrators, setting out educational and other qualifications, and providing that all nursing homes will have licensed administrators by July 1, 1970. S. B. 335 and companion bill S. 336 were enacted providing

(Continued on Page 370)

The Apprehensive Hypertensive



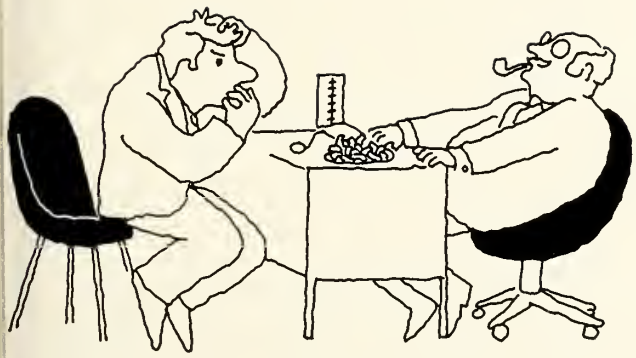


Regroton® to lower blood pressure

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Regroton®: chlorthalidone 50 mg., reserpine U.S.P. 0.25 mg.
Indications: Hypertension. *Contraindications:* History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. *Warning:* With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. *Precautions:* Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy the drug should be discontinued and potassium supplements given provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving

WE'VE GOT TO GET PLENTY OF REST AND TRY TO AVOID SITUATIONS THAT MAKE US ANXIOUS OR TENSE. AND WE'LL TAKE MEDICINE TO LOWER OUR BLOOD PRESSURE AND CALM US DOWN.



WE'VE GOT PROBLEMS.



and allay anxiety in hypertension

orticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones biliary colic may be precipitated). Bronchial asthma may occur in usceptible patients. *Adverse Reactions:* The drug is generally well olerated. The most frequent side effects are nausea, gastric irritation, omiting, diarrhea, constipation, muscle cramps, headache, dizziness nd acute gout. Other potential side effects include angina pectoris, nxiety, depression, bradycardia and ectopic cardiac rhythms (espeally when used with digitalis), drowsiness, dull sensorium, hyperglyemia and glycosuria, hyperuricemia, lassitude, restlessness, transient yopia, impotence or dysuria, orthostatic hypotension which may be otentiated when chlorthalidone is combined with alcohol, barbiturates narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytonia, agranulocytosis, nasal stuffiness, increased gastric secretions, ghtmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic rophy and glaucoma, and pruritus. Eruptions and/or flushing of the kin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. *Average Dosage:* One tablet daily with breakfast. *Availability:* Pink, single-scored tablets in bottles of 100 and 1000. (B)46-600-C

For details, please see complete prescribing information.

Regroton®
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

RE-6742

(Continued from Page 367)

for the use of a multiple choice examination by the Board of Medical Examiners and changing the fee for the examination to a flexible one between $75 and $150.

S. B. 393 changing the name of the Medical College of Alabama to University of Alabama School of Medicine passed on the last day of the session. S. B. 390 amended the Physical Therapy Practice Act to permit licensure of physical therapy assistants.

Several measures regulating drug traffic in Alabama were passed. S. B. 479 requires pharmacists to keep separate narcotic prescription files. This bill was introduced by Sen. Roland Cooper. S. B. 480 amends Title 22, Section 236 of the Code of Alabama to include synthetic cannabis within the dangerous drugs covered in that section. S. B. 482 provides $10,000 insurance coverage for State Health Department narcotics agents killed in the line of duty. S. B. 484 allows the seizure of vehicles used in transporting illegal drugs to be seized by law enforcement authorities.

A number of nursing scholarship bills to alleviate the severe nursing shortage in Alabama was introduced. However, in the log-jam at session's end all of these died except S. B. 501 providing 20 nursing scholarships for Troy State University at $600 each in 1970 and 30 nursing scholarships at $600 each in 1971.

Mental Health legislation receiving favorable action included: H. B. 733 providing for voluntary and temporary or emergency admissions of patients to mental hospitals or psychiatric facilities under certain conditions. H. B. 816 provides for the voluntary admission of the mentally retarded to State-owned and operated facilities for diagnosis, care, treatment, training, detention and/or rehabilitation of mentally retarded individuals. S. B. 850 provides for a proposed amendment to the Constitution of Alabama allowing a special property tax for general health purposes in Lawrence, Limestone and Morgan Counties. Should this amendment be adopted, it is speculated that revenues derived from this tax would be used to support mental health activities in these counties.

S. B. 277 regulating the type and format of forms used by the Bureau of Vital Statistics and allowing an increase in fees charged for copies of records was passed this session.

S. B. 8 provides for inspection of slaughter houses by the Department of Agriculture. This was one of the three bills opposed by MASA which passed. The bill transfers meat inspection from the Health Department, which has handled this function for 40 years, to the Department of Agriculture. An amendment to S. B. 8 allocates $500,000 to the Department of Agriculture for meat inspection during the next two fiscal years. An amendment also provides that the Department of Agriculture can contract with county health departments for certain aspects of its inspection responsibilities.

S. B. 301 and S. B. 302 provides for reallocation of cigarette tax revenues from the State Health Department to retire industrial development bonds. MASA opposition to these bills was based on the diversion of needed Health Department revenues to non-health functions.

SENATE BILLS

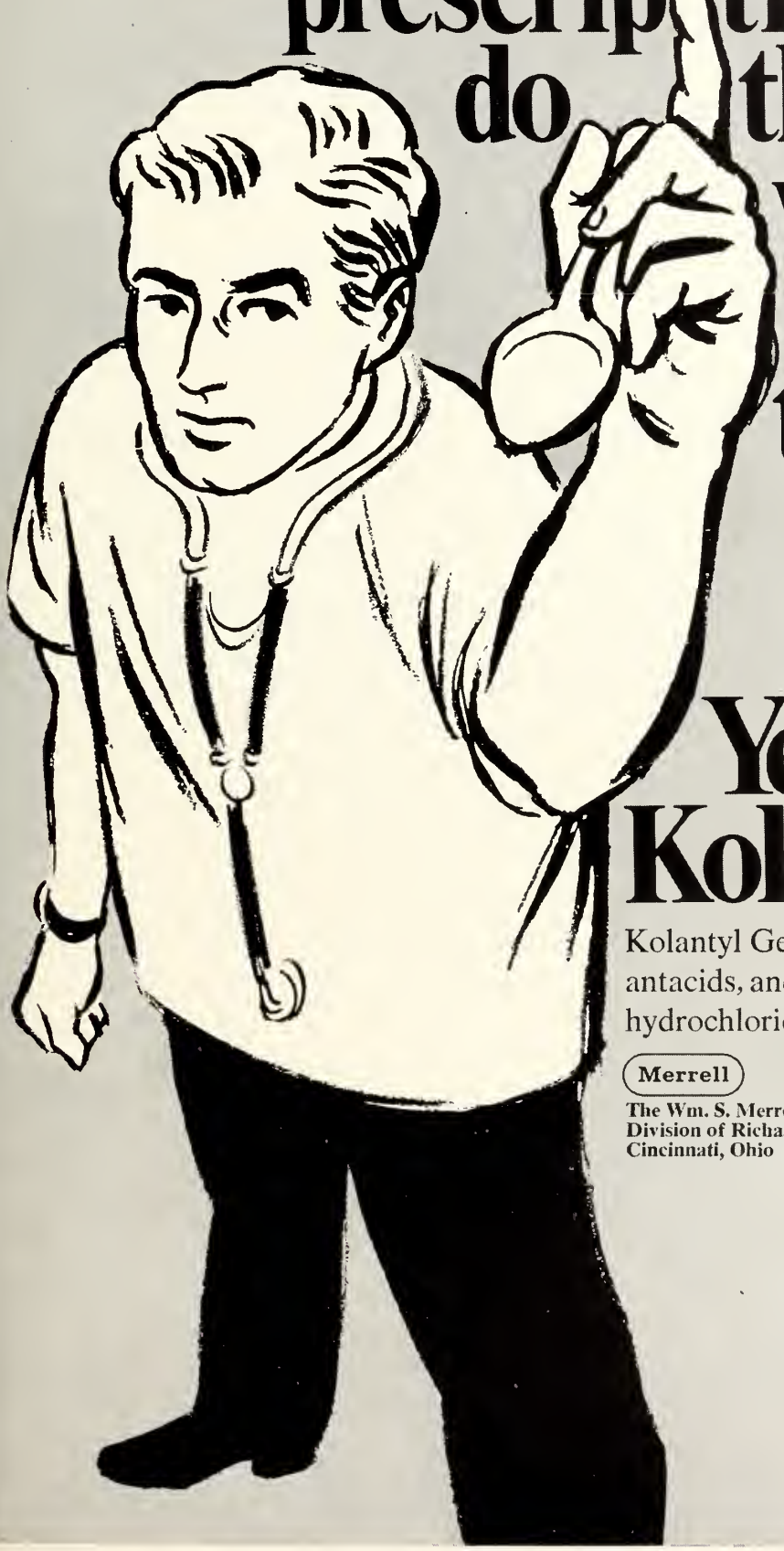
	SUBJECT	OUTCOME	MASA POSITION
S. 8	Provides for inspection of slaughter houses by Department of Agriculture.	Passed	Opposed
S. 11	Air pollution control administered by separate State Board.	Died in Committee	Opposed
S. 17	Amends Physical Therapy Practice Act to license director of Physical Therapy Department, Holy Name of Jesus Hospital, Gadsden.	Indefinitely Postponed	Opposed
S. 27	Establishes privileged communications between physicians and patients except under court order.	Died in Committee	Supported
S. 50	Defines authorized emergency vehicle.	Died	Supported
S. 70	Implied consent law to provide chemical tests to vehicle operators.	Passed	Supported
S. 77	Creates State Board of Examiners for Nursing Home Administrators.	Passed	Supported
S. 78	Provides for inspection of slaughter houses by Department of Health.	Indefinitely Postponed	Supported
S. 109	Appropriation for Montgomery Institute of Neurological Development.	Passed	No Position
S. 175	Air pollution control administered by 16 man board including State Health Officer and two physicians.	Indefinitely Postponed	Opposed
S. 190	Prohibits feeding garbage to swine.	Passed	No Position
S. 207	Provides sales and use tax exemptions for certain medicines purchased by prescription.	Indefinitely Postponed	Supported
S. 222	Amends Chiropractic Practice Act to enlarge scope to include gynecology, bacteriology, etc.	Indefinitely Postponed	Opposed
S. 223	Amends Chiropractic Practice Act to require 15 hours annually of professional studies.	Passed	No Position
S. 242	Amends Chiropractic Practice Act to permit suspension of license.	Passed	No Position
S. 251	Authorizes creation of public corporations to study, abate, etc., environmental pollution.	Passed	No Position
S. 272	Amends procedures relative to child adoption.	Indefinitely Postponed	No Position
S. 277	Allows fee increase, prescribes format etc., for certain forms in the Bureau of Vital Statistics, State Health Department.	Passed	Supported
S. 285	Authorizes reduction of sentences for convicts donating blood to Red Cross.	Died	No Position
S. 296	Provides 30 nursing scholarships at $600 per year to Jacksonville State University.	Indefinitely Postponed	Supported
S. 297	Provides 50 nursing scholarships at $350 per year to junior colleges.	Indefinitely Postponed	Supported
S. 298	Provides 28 nursing scholarships at $600 per year to Tuskegee Institute.	Indefinitely Postponed	Supported
S. 299	Provides 111 nursing scholarships at $600 per year to the University of Alabama in Birmingham.	Indefinitely Postponed	Supported
S. 300	Provides technical assistance to Board of Education by Board of Nursing for Junior College Nursing Programs.	Indefinitely Postponed	Supported

SENATE BILLS

	SUBJECT	OUTCOME	MASA POSITION
S. 301	Reallocation of cigarette tax revenues from State Board of Health to industrial development.	Passed	Opposed
S. 302	Pledges Health Department cigarette tax to pay principle and interest on industrial development bonds.	Passed	Opposed
S. 306	Permits chiropractors licensed in another state to practice in Alabama one year without examination.	Indefinitely Postponed	Opposed
S. 328	Authorizes suits to be filed against public hospitals; removes immunity from them.	Died in Committee	No Position
S. 335	Increases examination fee for medical licenses to not less than $75 or more than $150.	Passed	Supported
S. 336	Permits multiple choice examination questions on medical licensure examination.	Passed	Supported
S. 351	Prescribes penalties for habitual users of narcotics and alcohol who operate vehicles.	Indefinitely Postponed	Supported
S. 361	Prescribes standards for helmets worn by operators of two-wheel motorized vehicles.	Indefinitely Postponed	Supported
S. 378	Designates state and regional planning and development districts.	Passed	Supported
S. 381	Prohibits possession, sale, disposal and use of fireworks anywhere in the state.	Indefinitely Postponed	Supported
S. 382	Authorizes counties and cities to require inclusion of radioactive fallout protection in new buildings.	Indefinitely Postponed	No Position
S. 383	Requires use of fallout protection in all new buildings built with State funds.	Indefinitely Postponed	No Position
S. 390	Amends Physical Therapy Practice Act to permit licensure of Physical Therapy Assistants.	Passed	Supported
S. 393	Name change "Medical College of Alabama" to "The University of Alabama School of Medicine."	Passed	Supported
S. 427	Amends and prescribes law dealing in marijuana and certain drugs.	Indefinitely Postponed	Opposed
S. 428	Regulates water supplies, waste-water treatment plants; examine operators.	Indefinitely Postponed	Supported
S. 441	Provides directors of mental health authority need only be residents of area served by mental health authority.	Died	Supported
S. 455	Provides protective face screen devices for motorized cycle riders.	Indefinitely Postponed	Supported in Principle
S. 475	Establishes management services division with broad powers over other agencies of state government.	Indefinitely Postponed	Opposed
S. 476	Designates State Board of Health as training agency for ambulance operating personnel, establishes standards.	Indefinitely Postponed	Supported
S. 477	Relates to sewer systems, plumbing and gives certain powers to State-County Boards of Health.	Passed	Supported

(Continued on Page 374)

Can one prescription do the work of two?



Yes, Kolantyl®.

Kolantyl Gel/Wafers contain antacids, and Bentyl® (dicyclomine hydrochloride) too.

Merrell

The Wm. S. Merrell Company
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215

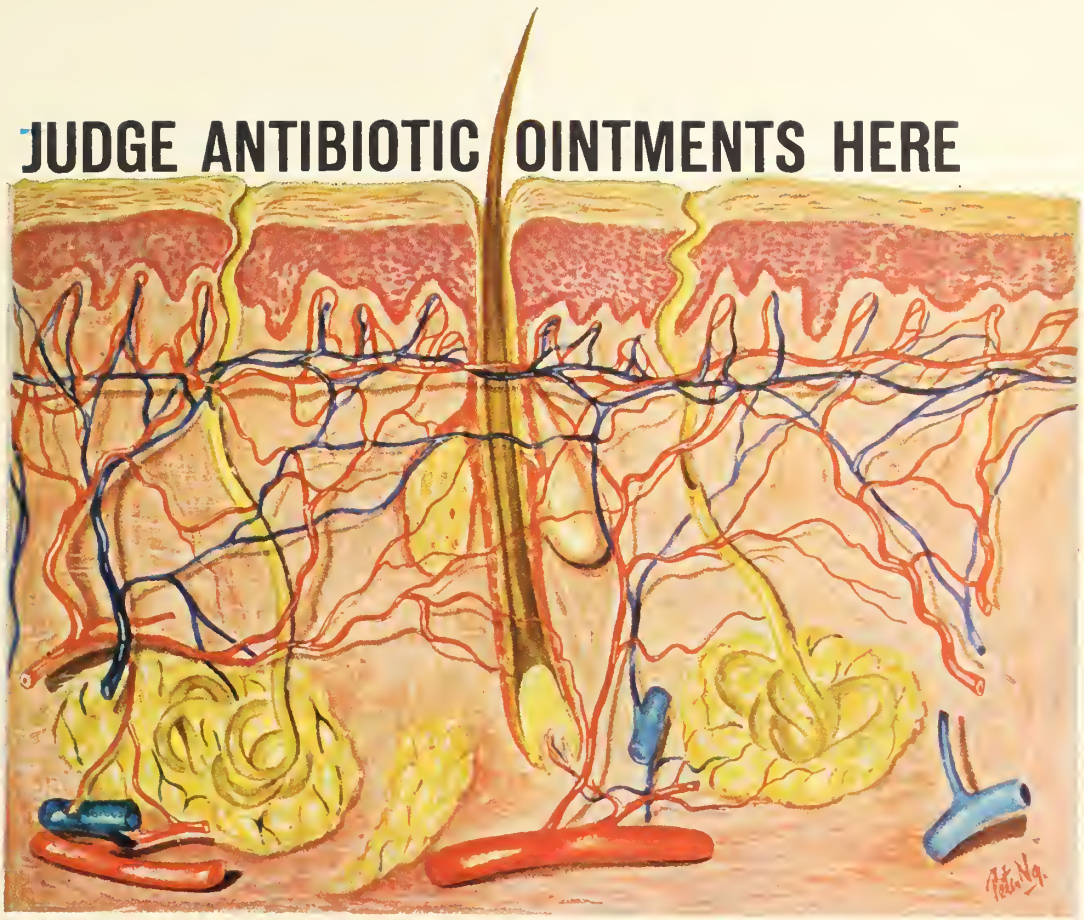
(Continued from Page 372)

SENATE BILLS

	SUBJECT	OUTCOME	MASA POSITION
S. 478	Provides for voluntary, temporary emergency admissions to certain mental facilities.	Passed	Supported
S. 479	Requires pharmacists to maintain separate narcotic prescription files.	Passed	Supported
S. 480	Includes tetrahydrocannabinol (synthetic cannabis) in prohibited category of Title 22, S. 236.	Passed	Supported
S. 481	Relates to misconduct and offenses of county officers.	Died	No Position
S. 482	Provides $10,000 insurance coverage for narcotics agents killed in line of duty.	Passed	Supported
S. 483	Provides that any person who sells, etc. any §242 narcotic is guilty of a felony instead of a misdemeanor.	Died in Committee	Supported
S. 484	Provides for seizure of vehicles transporting or conveying illegal drugs.	Passed	Supported
S. 488	Change membership of Alabama Water Improvement Commission.	Indefinitely Postponed	Opposed
S. 500	Regulates construction of water wells; creates water wells standards Board.	Indefinitely Postponed	No Position
S. 501	Nursing scholarships for Troy State University 20 at $600—1970, 30 at $600—1971.	Indefinitely Postponed	Supported
S. 520	Air pollution control 12 man commission, 4 M. D.s.	Passed	Supported
S. 521	Corporate income tax deduction for air, water pollution control devices.	Passed	Supported
S. 522	Ad valorem tax exemption for air, water pollution control equipment.	Passed	Supported
S. 523	Foreign corporation franchise tax credits for air, water pollution control equipment.	Passed	Supported
S. 524	Sales tax credit for air, water pollution control equipment devices.	Passed	Supported
S. 525	Provides for tax credit on stock evaluation for value of pollution control devices.	Passed	Supported
S. 526	State use tax exemption on storage, use, consumption of air, water pollution control equipment.	Passed	Supported
S. 527	Prescribes circumstances for sterilization of mentally retarded; provides physician immunity.	Indefinitely Postponed	Supported
S. 548	Air pollution control 16 man commission, State Health Officer, Chairman, 2 other M. D.'s.	Indefinitely Postponed	Opposed
S. 562	Privileged communications between psychotherapists and patients.	Indefinitely Postponed	No Position
S. 602	Permits counties, (65M to 95M population), or municipalities within such counties to establish ambulance services.	Passed	Supported

(Continued on Page 379)

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

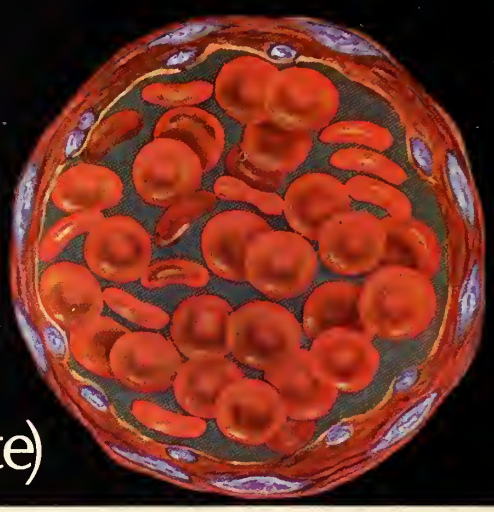
'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Roniacol® Timespan®
(nicotinyl alcohol tartrate)



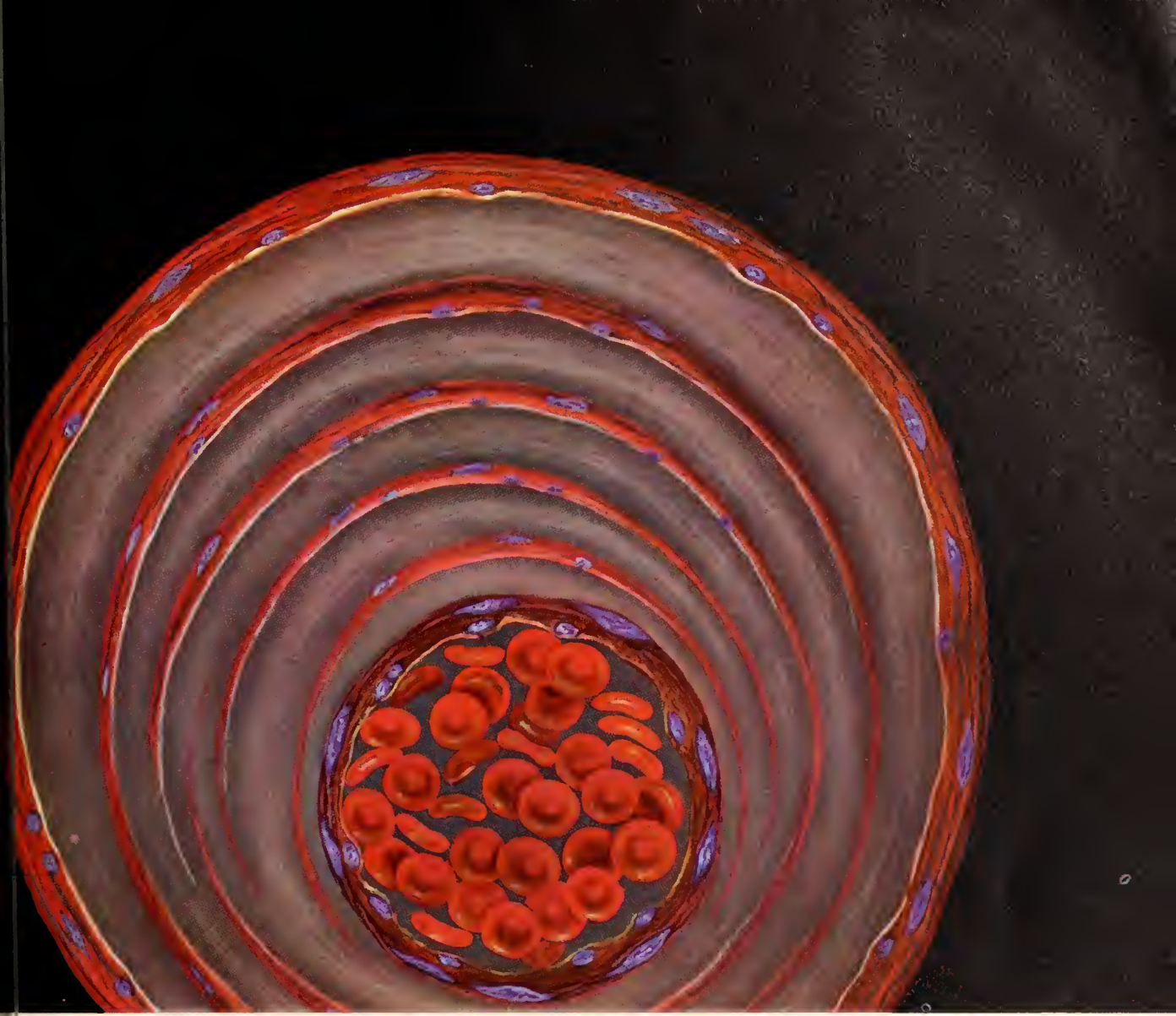
Because peripheral vasodilatio is needed now... and must often be continued

Roniacol Timespan (nicotinyl alcohol tartrate) can make a significant contribution to effective treatment of peripheral vascular disorders. It is directed specifically toward improvement of peripheral blood flow, relief of ischemic symptoms, and the long-term management of these conditions.

Specific pharmacologic action—Roniacol (nicotinyl alcohol) acts selectively by relaxing smooth muscle of peripheral blood vessels. Onset of action is smooth and gradual, rarely causing severe flushing.

Relative freedom from side effects—Side effects that may occur occasionally with Roniacol seldom require discontinuation of therapy.

Prolonged, continuous drug release—Prolonged peripheral vasodilation is provided b sustained-release Roniacol Timespan (nicot alcohol tartrate) Tablets. Part of the drug be comes available immediately, the remainde continuously over a period of up to 12 hour and dilation of constricted peripheral vessel usually maintained. Thus, with a single dose medication, patients can enjoy the benefits increased peripheral blood flow in ischemic extremities for up to 12 hours.



Smooth peripheral vasodilation from initial dosage...extended with simple, well-tolerated, b.i.d. dosage

The prolonged action of Roniacol Timespan (nicotinyl alcohol tartrate) together with its other benefits offer a therapeutically practical measure in the long-term management of peripheral vascular disease–advantages especially important for older patients.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Conditions associated with deficient circulation; e.g., peripheral vascular disease, vascular spasm, varicose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

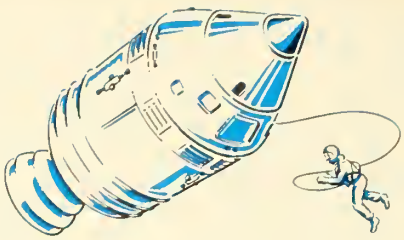
Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50 and 500.

ROCHE

Roche
LABORATORIES
Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Art is a conception of peripheral vasodilation.



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, *300 mg.;* SODIUM ACID PHOSPHATE, *500 mg.*

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals

(Continued from Page 374)

SENATE BILLS

	SUBJECT	OUTCOME	MASA POSITION
S. 616	Removes age limit for admission to Partlow State School and Hospital.	Indefinitely Postponed	Supported
S. 651	Regulates feeding garbage to swine, designed to prevent spread of livestock diseases.	Passed	No Position
S. 666	Provides for voluntary admissions to state-owned mental hospitals, facilities.	Indefinitely Postponed	Supported in Principle
S. 671	Provides that certain state agencies, boards, etc., shall keep all state funds in State Treasury.	Indefinitely Postponed	Opposed
S. 675	Includes services of all licensees of branches of healing arts under policies issued in Alabama.	Indefinitely Postponed	Opposed
S. 677	In counties 300M-500M authorizes municipalities to enter agreements with public corporations for garbage collection.	Passed	No Position
S. 680	Exempts medical clinic boards from Alabama usury and interest rate limit laws.	Passed	No Position
S. 681	Regulates cropdusting with aircraft.	Died	Supported in Principle
S. 689	Air pollution control measure.	Indefinitely Postponed	Opposed
S. 692	Provides for licensure of radiologic technologists, creates Board of Radiologic Examiners.	Passed	Supported in Principle
S. 725	Makes an appropriation to University of Alabama Medical Center for School of Community and Allied Health Resources.	Passed	Supported
S. 728	Air pollution control measure.	Indefinitely Postponed	Opposed
S. 729	Air pollution control measure.	Indefinitely Postponed	Opposed
S. 730	Appropriation for air pollution control fund.	Indefinitely Postponed	Opposed
S. 731	Exempts from sales and use tax feeds for animals used in scientific and medical research.	Indefinitely Postponed	Supported in Principle
S. 757	Provides for leasing of public hospitals, health centers and related facilities.	Died	No Position
S. 850	Constitutional amendment to allow special property tax for general health purposes in Lawrence, Limestone and Marshall counties.	Passed	Supported
S. 893	Amends Section 269(b), Title 46 to include Mental Health facilities under its provisions.	Indefinitely Postponed	Supported

HOUSE BILLS

	SUBJECT	OUTCOME	MASA POSITION
H. 7	Authorizes state income tax deduction for medical, dental expenses, drugs, health and accident insurance premiums.	Indefinitely Postponed	Supported
H. 42	Creates State Board of Examiners of Nursing Home Administrators.	Indefinitely Postponed	Supported

(Continued on Page 381)



The Bradley Center --- for the problems of living

An all new homelike open psychiatric residence on a lovely five-acre tract, centrally located within the community, providing a comprehensive range of continuous services, including in-patient, day care, and outpatient treatment. Each patient participates in an extensive and intensive treatment program, based almost exclusively upon multiple psychotherapeutic encounters. These include individual psychotherapy, group psychotherapy, the nursing milieu, occupational therapy, recreational therapy, topical small group discussions, and other group activities in the Center, as well as in the community, depending on individual needs and interests. Medications are prescribed when appropriate.

Any individual may be admitted who, in the opinion of the medical staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible family member.

Accredited by the Joint Commission on Accreditation of Hospitals.

Leonard T. Maholick, M. D.
Medical Director

Maj. Gen. (ret.) Howard Snyder
Administrator

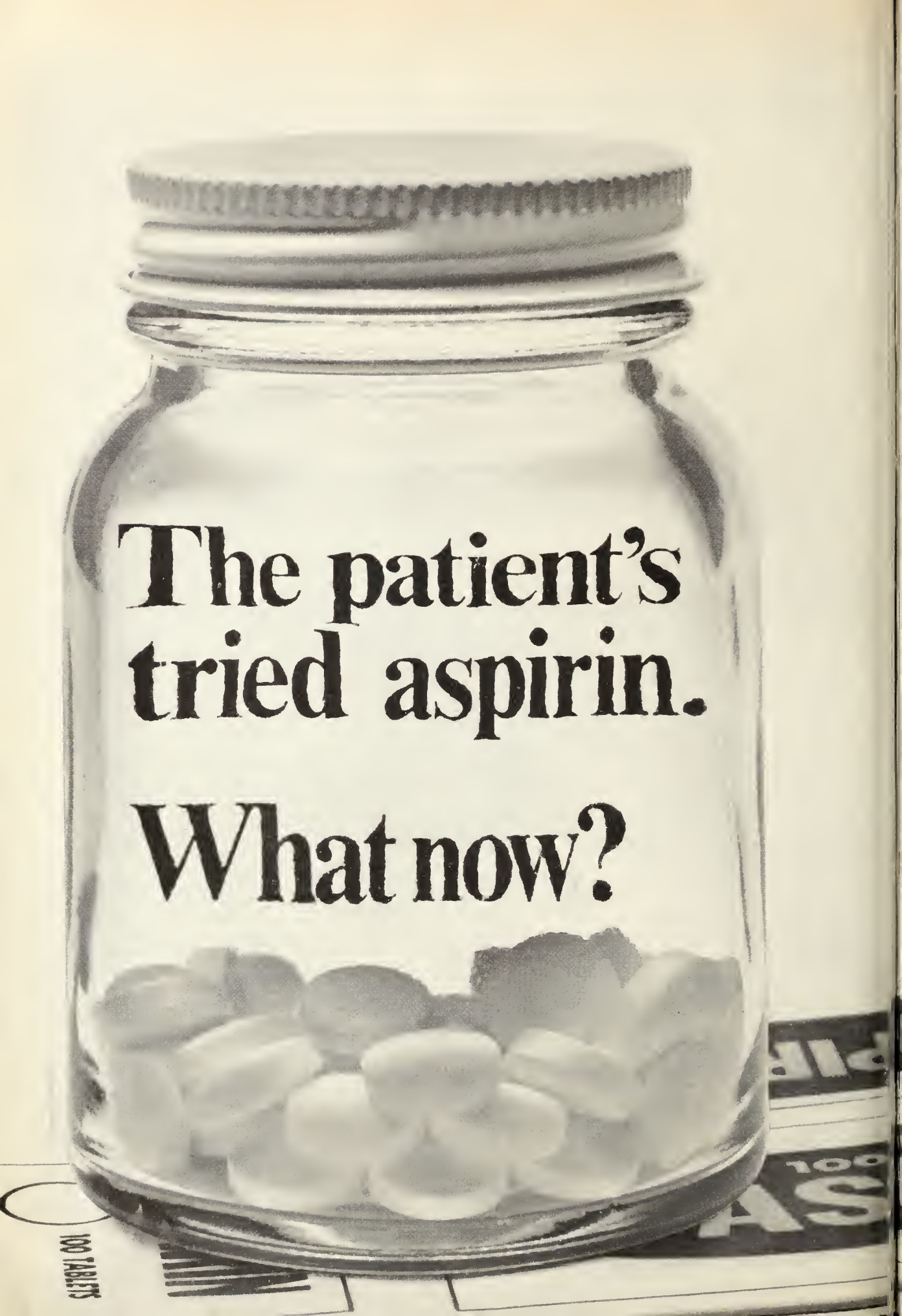
THE BRADLEY CENTER, INC.
2000 Sixteenth Avenue
Columbus, Georgia 31901
Area Code 404 324-4882

(Continued from Page 379)

HOUSE BILLS

	SUBJECT	OUTCOME	MASA POSITION
H. 47	Implied consent law to provide chemical tests to vehicle operators.	Indefinitely Postponed	Supported in Principle
H. 68	Amends Physical Therapy Act to license director of Physical Therapy Department, Holy Name of Jesus Hospital, Gadsden.	Indefinitely Postponed	Opposed
H. 111	Prohibits sale or exhibition of any pornographic material to a minor.	Passed	Supported
H. 121	Provides licensure of dealers and salesmen of hearing aids by Board of Hearing Aid Dealers.	Indefinitely Postponed	Supported
H. 125	Regulates cancellation and alteration of hospital, medical insurance policies.	Indefinitely Postponed	Supported
H. 129	Provides tuition grants to parents of mentally retarded persons denied admittance to Partlow due to crowded conditions.	Indefinitely Postponed	Opposed
H. 134	Authorizes blood tests on cattle to determine the existence of brucellosis.	Indefinitely Postponed	Opposed
H. 149	Air pollution control administered by separate State Board.	Indefinitely Postponed	Opposed
H. 152	Authorizes government hospitals to submit copies of records as evidence.	Indefinitely Postponed	Supported
H. 169	Provides for inspection of slaughter houses by Department of Agriculture.	Indefinitely Postponed	Opposed
H. 197	Provides financial assistance for handicapped children including dyslexia.	Passed	No Position
H. 198	Provides for inspection of slaughter houses by Department of Health.	Indefinitely Postponed	Supported
H. 200	Prohibits inhalation of model glue.	Indefinitely Postponed	Supported
H. 201	Requires health certificates for food handlers.	Died	Supported
H. 206	Exempts prescription drugs and medicine from sales and use tax.	Indefinitely Postponed	Supported
H. 212	Authorizes municipalities to pay hospital medical expenses of injured employees.	Indefinitely Postponed	No Position
H. 239	Prohibits feeding garbage to swine.	Indefinitely Postponed	No Position
H. 246	Implied consent law to provide chemical tests to vehicle operators.	Indefinitely Postponed	Supported in Principle
H. 261	Amends requirements related to consent to adoption of children.	Died	No Position
H. 268	Provides sales and use tax exemptions for certain medicines purchased by prescription.	Indefinitely Postponed	Supported
H. 279	Establishes safety standards for school buses.	Passed	Supported
H. 281	Medicaid tax on whiskey—5% increase.	Passed	Supported
H. 282	Medicaid tax on Cigarettes—$.01 per package.	Passed	Supported
H. 283	Medicaid tax on Beer—$.01 per can.	Passed	Supported

(Continued on Page 384)


The patient's
tried aspirin.
What now?
100 TABLETS

There's a good chance your patient needs more than a non-prescription analgesic for pain relief. Especially after self-medication has failed.

Because continuing, increased pain and discomfort may in part be a reflection of anxiety, Equagesic is worthy of consideration. In a single, non-narcotic preparation, it helps relieve pain . . . *and* associated anxiety and tension.

Tablets

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

IN BRIEF

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

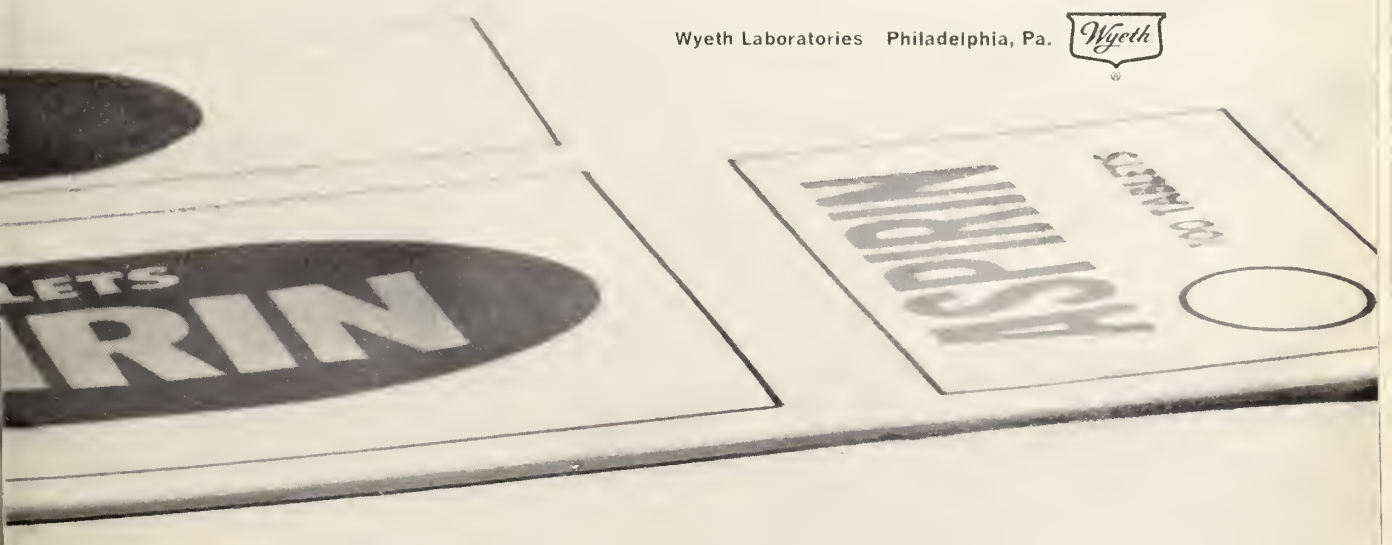
Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa. Wyeth®



(Continued from Page 381)

HOUSE BILLS

	SUBJECT	OUTCOME	MASA POSITION
H. 304	Amends Chiropractic Practice Act to require 15 hours annually of professional studies.	Indefinitely Postponed	No Position
H. 338	Amends Chiropractic Practice Act to enlarge scope to include gynecology, bacteriology, etc.	Indefinitely Postponed	Opposed
H. 346	Permits chiropractors licensed in another state to practice in Alabama 1 year without examination.	Indefinitely Postponed	Opposed
H. 371	Implied Consent law to provide chemical tests to vehicle operators.	Indefinitely Postponed	Supported in Principle
H. 377	Proclaims white cane safety day; relates to rights of handicapped persons.	Died	Supported
H. 379	Sets out offenses and prescribes penalties for habitual users of narcotics and alcohol who operate vehicles.	Indefinitely Postponed	Supported
H. 380	Relates to uniform blood alcohol tests standards; limits liability for tests administrator.	Indefinitely Postponed	Supported
H. 391	Authorizes counties and municipalities to provide non-profit ambulance services.	Indefinitely Postponed	Supported
H. 394	Provides standards for health and safety in existing and future public facilities seating 600 or more persons.	Indefinitely Postponed	Supported
H. 397	Implied consent law to provide chemical tests to vehicle operators.	Indefinitely Postponed	Supported in Principle
H. 408	Provides 111 nursing scholarships at $600 per year to the University of Alabama in Birmingham.	Died	Supported
H. 409	Provides 28 nursing scholarships at $600 per year to Tuskegee Institute.	Died	Supported
H. 410	Provides 30 nursing scholarships at $600 per year to Jacksonville State University.	Died	Supported
H. 411	Provides 50 nursing scholarships at $350 per year to junior colleges.	Died	Supported
H. 412	Provides technical assistance to Board of Education by Board of Nursing for junior college nursing programs.	Died	Supported
H. 435	Requires flouridation of public water supplies.	Indefinitely Postponed	Supported in Principle
H. 453	Implied consent law to provide chemical tests to vehicle operators.	Indefinitely Postponed	Supported in Principle
H. 454	Amends Chiropractic Practice Act to permit suspension of license.	Indefinitely Postponed	No Position
H. 458	Provides for safety inspection of bridges.	Died	Supported
H. 467	Prescribes sewer standards in counties over 500,000.	Passed	Supported
H. 473	Provides standards for health and sanitary conditions of nursery schools and kindergartens.	Indefinitely Postponed	Supported
H. 488	Provides penalties for driving while habitually using drugs or while intoxicated.	Indefinitely Postponed	Supported in Principle
H. 515	Permits multiple choice examination questions on medical licensure examination.	Indefinitely Postponed	Supported

(Continued on Page 386)

One of the best things you can do for the cold sufferer



Ornade® Spansule®

brand of sustained release capsules

Trademark

Each capsule contains 8 mg of Teldrin® (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

Prompt relief from nasal congestion and hypersecretion due to colds.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*

Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.

Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness

Usage In Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.

Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.

Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

SK&F Smith Kline & French Laboratories

(Continued from Page 384)

HOUSE BILLS

	SUBJECT	OUTCOME	MASA POSITION
H. 516	Increases examination fee for medical licenses to not less than $75 or more than $150.	Indefinitely Postponed	Supported
H. 566	Requires use of fallout protection in all new buildings built with state funds.	Passed	Supported in Principle
H. 567	Authorizes counties and cities to require inclusion of radio-active fallout protection in new buildings.	Passed	Supported in Principle
H. 607	Implied consent law to provide chemical tests to vehicle operators.	Indefinitely Postponed	Supported in Principle
H. 625	Includes services of all licensees of branches of healing arts under policies of insurance issued in Alabama.	Indefinitely Postponed	Opposed
H. 628	Implied consent law to provide chemical tests to vehicle operators.	Indefinitely Postponed	Supported in Principle
H. 635	Exempts publicly owned medical clinics from the legal requirements of the State and municipal contract laws.	Passed	No Position
H. 643	Provides for state planning and development districts.	Indefinitely Postponed	No Position
H. 649	Amends Physical Therapy Practice Act to permit licensure of Physical Therapy Assistants.	Indefinitely Postponed	Supported
H. 658	Classify public water supply and waste water treatment facilities, examine and certify operators of same.	Indefinitely Postponed	Supported
H. 661	Provides for the regulation of teaching and practice of cosmetology and creating a State Board of Cosmetology.	Indefinitely Postponed	No Position
H. 674	Implied consent law to provide chemical tests to vehicle operators.	Indefinitely Postponed	Supported in Principle
H. 690	Change membership of Alabama Water Improvement Commission.	Indefinitely Postponed	Opposed
H. 733	Provides for voluntary, temporary, emergency admissions to certain mental facilities.	Passed	Supported
H. 735	Provides Directors of Mental Health Authority need only be residents of area served by Mental Health Authority.	Died	Supported
H. 749	Prescribes standards for litter and sewerage disposal from watercraft; penalties.	Passed	Supported
H. 771	Provides protective face screen devices for motorized cycle riders.	Indefinitely Postponed	Supported
H. 784	Implied consent law to provide chemical tests to motor vehicle operators.	Indefinitely Postponed	Supported in Principle
H. 796	Provides for proper disposal of solid waste products.	Passed	Supported
H. 803	Nursing scholarships for Troy State University.	Passed	Supported
H. 808	Authorize suits to be filed against public hospitals removes immunity from them.	Indefinitely Postponed	No Position
H. 816	Voluntary admission to state mental hospitals, facilities.	Passed	No Position
H. 818	Prohibits thermoplastic pipe in drain, waste or vent use.	Indefinitely Postponed	Supported

(Continued on Page 391)

Because any urologic infection can be serious, **BREON** introduces potent therapy

for the strong start and a fast finish...

"...a significant gap appears to have been closed in the armory of drugs available to the urologist."[1]
Bacteriuria and symptoms can be eliminated within 48 to 72 hours; susceptible infection often in 10 to 14 days.

before your "minor" becomes a major problem

choice initial treatment for urinary infections

Cybis® (nalidixic acid) provides prompt broad gram-negative bactericidal activity at normal urinary pH range that can eradicate troublesome *E. coli,* Aerobacter and Proteus. A good starting drug, it can effectively accelerate management of infection due to sensitive organisms.

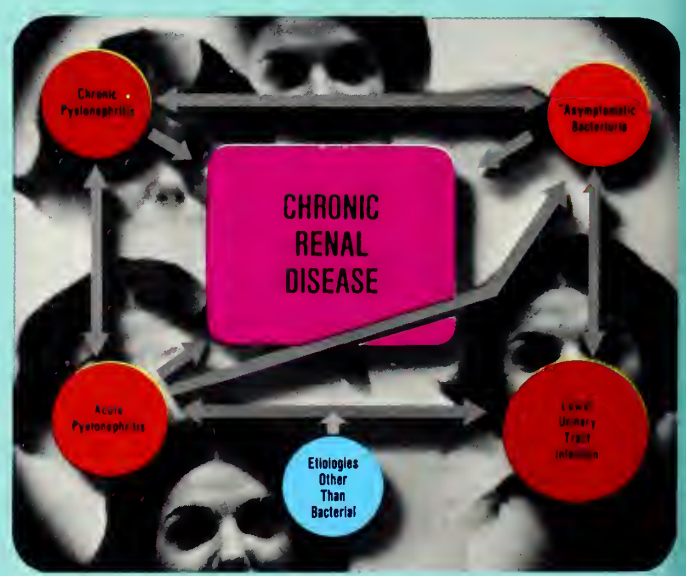
essential control within the primary 72-hour cycle

In cases of acute infection due to susceptible organisms, Cybis works well toward the rapid clearing of disease when obstruction is absent or can be relieved. Within 48 to 72 hours, symptoms are frequently eased and bacteriuria eliminated. Susceptible infection is often eradicated in 10 to 14 days.

blocks the young female progression of infection

Cybis can be useful in naturally susceptible young female patients with new or well-established urinary disturbances. Combining rapid potency with relative freedom of serious side reactions and toxicity, the drug can be of particular value in preventing higher tract involvement or blocking the possible continuum of disease. (See Chart)

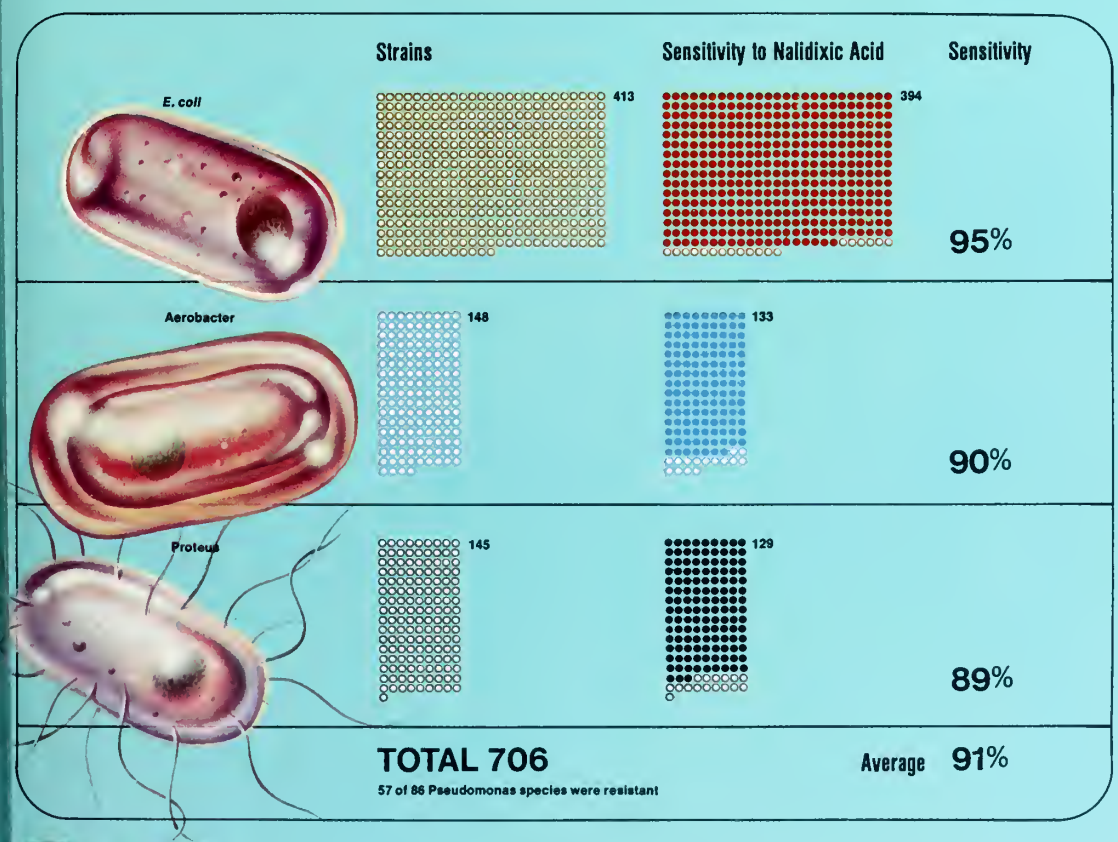
Kinetic Relationship of Acute and Chronic Bacterial Pyelonephritis to Chronic Renal Disease[2]



consistent activity against 706 gram-negative strains

In vitro testing of *E. coli*, Aerobacter and Proteus species showed better than 90% sensitivity to nalidixic acid.[3] (See Table)

Better Than 90% Sensitivity Among 3 Common Urinary Invaders



References: 1. Reimann-Hunziker, R. and Reimann-Hunziker, G. J.: *Praxis* 53:15, Jan. 9, 1964. 2. Sanford, J. P.: *Med. Times* 96:715, July 1968. 3. Reese, L.: *Canad. M. A. J.* 92:394-397, Feb. 20, 1965.

Cybis®
(nalidixic acid)

for the strong start and a fast finish... in cystitis, pyelonephritis, prostatitis, urethritis

Before prescribing, please consult complete product information, a summary of which follows on the next page, including indications, warning, precautions, adverse reactions and dosage.

Summary of prescribing information

Indications: Urinary tract infections in which species of sensitive gram-negative bacteria are predominant, particularly *Proteus, Escherichia coli, Aerobacter, Klebsiella,* and certain strains of *Pseudomonas.* Gram-positive bacteria are less sensitive to Cybis but favorable clinical results have been observed.

Warning: Use in Pregnancy. This drug is not recommended in the first trimester of pregnancy. However, it has been used in several patients during the last two trimesters without producing apparent ill effects in either mother or fetus.

Precautions: Although prolonged treatment with Cybis has been generally well tolerated, as with all new drugs it is advisable to carry out blood, renal, and liver function tests periodically if treatment is continued for more than one or two weeks. The dosage recommended for adults and children should not be arbitrarily doubled unless under the careful supervision of a physician. **It should be used with caution in patients with liver disease, epilepsy, or severe cerebral arteriosclerosis, and in patients in whom kidney function is severely impaired.** Patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving Cybis and, if a photosensitivity reaction occurs, therapy should be discontinued.

During treatment microorganisms may develop resistance to this drug. Resistant bacteria, not previously present or identified, may emerge. Cultures should be taken and bacterial sensitivity tests made periodically, particularly if the clinical response is unsatisfactory or if a relapse occurs. Should resistance develop, other specific chemotherapy should be instituted; no cross resistance has been observed. If new strains of bacteria that are not sensitive emerge, other effective antibacterial agents may be added. When Benedict's or Fehling's solutions or Clinitest® Reagent Tablets are used to test the urine of patients taking Cybis, a false-positive reaction for glucose may be obtained due to the liberation of glucuronic acid from the metabolites excreted. However, a colorimetric test for glucose based on an enzyme reaction (using, for example, Clinistix® Reagent Strips or Tes-Tape®) does not give a false-positive reaction to Cybis glucuronide.

Adverse reactions: Mainly mild nausea, vomiting, and other gastrointestinal disturbances: less frequently, sleepiness, drowsiness, weakness, headache, dizziness and vertigo, and rarely cholestasis, paresthesia, thrombocytopenia, leukopenia, or hemolytic anemia which in some patients may have been associated with deficiency in activity of glucose-6-phosphate dehydrogenase. Itching, pruritus, rash, urticaria, mild eosinophilia, reversible photosensitivity reactions primarily involving exposed surfaces, and reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), occurred occasionally. Reversible increased intracranial pressure with bulging anterior fontanel, papilledema, and headache have been observed occasionally in infants and children. Toxic psychosis and brief convulsions (the latter generally in patients with possible predisposing factors, and both usually associated with excessive dosage) have been recorded in rare instances.

Dosage and administration: *Adults*—Four Gm. daily by mouth (2 tablets of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily (1 tablet of 500 mg. four times daily). *Children*—According to age and weight: approximately *25 mg. per pound* of body weight per day, administered in divided doses.

Note: The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied: Tablets of 500 mg., bottles of 50.

Before prescribing, please refer to complete prescribing information.

Cybis®

(nalidixic acid)

for the strong start and a fast finish...

in cystitis
pyelonephritis
prostatitis
urethritis





BREON

BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016
Subsidiary of Sterling Drug Inc.

(Continued from Page 386)

HOUSE BILLS

	SUBJECT	OUTCOME	MASA POSITION
H. 822	Regulates fluoridation of water supplies in counties population 400,000 or more.	Passed	Supported in Principle
H. 831	Prescribes circumstances for sterilization of mentally retarded; provides physician immunity.	Indefinitely Postponed	Supported
H. 832	Air pollution control, 12 man commission 4 M. D.'s.	Died	Opposed
H 833	Ad valorem tax exemption for air, water pollution control equipment.	Died	Supported
H. 834	Provides for tax credit on stock evaluation for value of pollution control devices.	Died	Supported
H. 835	Sales tax credit for air, water pollution control equipment devices.	Died	Supported
H. 836	Corporate income tax deduction for air, water pollution control devices.	Died	Supported
H. 837	State use tax exemption on storage, use, consumption of air, water pollution control equipment.	Died	Supported
H. 838	Foreign Corporation franchise tax credits for air, water pollution control equipment.	Died	Supported
H. 845	Implied consent law to provide chemical tests to motor vehicle operators.	Indefinitely Postponed	Supported in Principle
H. 856	Implied consent law to provide chemical tests to motor vehicle operators.	Indefinitely Postponed	Supported Principle
H. 875	Provides for creation of State Board of Cosmetology; regulates teaching and practice.	Died	No Position
H. 889	Provides certain number of teachers for exceptional children.	Passed	No Position
H. 892	Allows Alabama Public School and College Authority to sell additional capital improvement bonds.	Passed	No Position
H. 897	Prohibits use of public funds for sex education below 9th grade level and regulates sex education courses.	Indefinitely Postponed	Opposed
H. 961	Prohibits use of public school funds for sex education and regulates teaching of sex education in general.	Died	Opposed
H. 970	Implied consent law to provide chemical tests to vehicle operators.	Indefinitely Postponed	Supported in Principle
H. 979	Authorizes $2 fee on motor vehicle licenses for Mental Health Purposes.	Indefinitely Postponed	No Position
H. 1005	Provides license and tax exemption for North Alabama Tuberculosis Association.	Died	No Position
H. 1010	Implied consent law to provide chemical tests to vehicle operators.	Indefinitely Postponed	Supported in Principle
H. 1037	Repeals Jefferson County Cosmetology Act of 1931.	Passed	No Position
H. 1038	Regulates teaching, practice of cosmetology in Alabama.	Passed	No Position

(Continued on Page 392)

(Continued from Page 391)

HOUSE BILLS

	SUBJECT	OUTCOME	MASA POSITION
H. 1041	Allows counties with license or excise taxes for public health facilities to issue warrants of indebtedness.	Died	No Position
H. 1097	Implied consent law to provide chemical tests to vehicle operators.	Indefinitely Postponed	Supported in Principle
H. 1112	Regulates cropdusting with aircraft.	Indefinitely Postponed	Supported in Principle
H. 1119	Regulates feeding of raw garbage to swine.	Indefinitely Postponed	Supported in Principle
H. 1125	Implied consent law to provide chemical tests to vehicle operators.	Indefinitely Postponed	Supported in Principle
H. 1174	Provides capital and operating funding for county health departments from county's general fund.	Died	Supported in Principle
H. 1175	Provides capital and operating funding for county health departments from general funds of incorporated municipalities.	Died	Supported in Principle
H. 1177	Requires chiropractors be graduates of schools accredited by the U. S. Office of Education to be licensed in Alabama.	Indefinitely Postponed	Supported
H. 1185	Regulates release of toxic and dangerous pollutants in public waters, prescribes measure of damages for violations.	Indefinitely Postponed	Supported in Principle
H. 1199	Provides sales and use tax exemptions on certain prescription medicine.	Indefinitely Postponed	Supported in Principle
H. 1209	Implied consent law to provide chemical tests to vehicle operators.	Indefinitely Postponed	Supported in Principle
H. 1236	Air pollution control measure.	Indefinitely Postponed	Opposed
H. 1238	Includes services of all licensees of branches of healing arts under policies of insurance issued in Alabama.	Died	Opposed
H. 1239	Implied consent law to provide chemical tests to vehicle operators.	Indefinitely Postponed	Supported in Principle
H. 1277	Provides for licensure of radiologists and creates a Board of Radiologic Examiners.	Indefinitely Postponed	Supported in Principle
H. 1289	Regulates stream pollution in counties.	Indefinitely Postponed	Supported in Principle
H. 1291	Implied consent law to provide chemical tests to vehicle operators.	Indefinitely Postponed	Supported in Principle
H. 1309	Authorizes each county/municipality to establish, operate junk collection, disposal and abatement systems, authorizes study commissions for same.	Indefinitely Postponed	Supported
H. 1313	Provides penalties for child abuse.	Died	Supported
H. 1315	Authorizes public corporations for water, sewer, fire protection services within counties.	Died	No Position
H. 1355	Amends Title 22 §258 changing penalty on possession, dealing in, etc., marijuana and certain other drugs.	Indefinitely Postponed	Supported in Principle

HOUSE BILLS

	SUBJECT	OUTCOME	MASA POSITION
H. 1356	Implied consent law to provide chemical tests to vehicle operators.	Indefinitely Postponed	Supported in Principle
H. 1377	Child abuse measure applicable in counties (110M to 160M) requiring reporting of non-accidental injuries, etc.	Passed	Supported in Principle
H. 1378	Amends Alabama Code, Title 46 §262 to exempt medical students and interns from its provisions.	Died	Supported
H. 1379	Amends Alabama Code, Title 46 §257(2) to exempt medical students and interns from its provisions.	Died	Supported
H. 1431	Amends Title 46, Section 210 to clarify who may own and operate optometry establishments.	Indefinitely Postponed	No Position
H. 1433	Provides for municipal operation of non-profit ambulance services in all counties 46.5M-48M population.	Died	No Position
H. 1446	Implied consent law to provide chemical tests to vehicle operators.	Indefinitely Postponed	Supported in Principle
H. 1501	Includes certain county health department employees under State health insurance plan, amending Act #833, 1965.	Indefinitely Postponed	No Position
H. 1517	Provides sales-use tax exemption for South Alabama Chapter of National Multiple Sclerosis Society.	Indefinitely Postponed	No Position
H. 1550	Amends Section 269(b) of Title 46 to provide that state mental health facilities can be included in its provisions.	Indefinitely Postponed	No Position

Chiropractor Hypnotizes Ball Team Into Playing Better

Now it can be told.

Under a heading, "The Inside Story," the Sports Editor of the Montgomery Advertiser made a medical diagnosis of the Montgomery Rebels, the baseball club that finished on the lip of the cellar in the Southern League, and emerged with the following:

"Eight members of the team asked for and underwent hypnosis.

"Dr. Nelson Decker, the trainer who is a Doctor of Chiropractic and a licensed hypnotist, held sessions with the eight players.

"One he turned down for fear the player would become violent.

"These were no party tricks. It was serious business. Doc simply attempted to make the players think positively, to have a positive attitude, not to be defeatist.

"Each player was limited to two treatments, no more.

"There did appear to be results. One pitcher had his greatest season ever. Another, pounded hard most of the year, had a string of five or six fine performances in a row."

One could add constructively that the Rebels did not finish in last place. Only next to last.

Norflex®
(orphenadrine citrate, 100 mg.)

Takes the agony out of low back pain



Take the agony out of low back pain... Norflex® (orphenadrine citrate) relaxes the muscles in spasm.

Restore mobility and hasten recovery... prescribe Norflex 1 tablet b.i.d.

Indications: Acute spasm of voluntary muscles, regardless of location; especially post-traumatic, discogenic, and tension spasms. **Contraindications:** Due to its anticholinergic action, NORFLEX should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcer, prostatic hypertrophy or obstruction at the bladder neck, cardiospasm (megaesophagus) and myasthenia gravis. Use with caution in patients with tachycardia. Do not use propoxyphene (Darvon®) concurrently. **Adverse Reactions:** Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Adverse reactions are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported. **Dosage and Administration:** Two tablets per day for adults, regardless of weight or sex; one in the morning and one in the evening. Each tablet contains 100 mg. orphenadrine citrate.
For full information, see Package Insert or P.D.R.

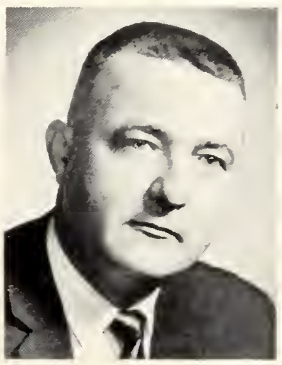
Norflex®
(orphenadrine citrate)

Riker Laboratories
Div. of Dart Industries Inc.
Northridge, California 91324

The Riker representatives in your area are:
Robert Johnston
Billy J. Phillips
William O. Crabb
Paul E. Loeffler III

ALAPAC Board To Meet Nov. 2 To Broaden Scope Of Activity

The Alabama Medical Political Action Committee's Board of Directors, who met in Montgomery last month immediately following adjournment of the Legislature, will reconvene next month—on Sunday, November 2nd, in Montgomery—to discuss developing plans for 1970.



Dr. Murchison

Dr. Grover C. Murchison, Jr., Montgomery, is chairman of ALAPAC; Dr. John C. Sullivan, also of Montgomery, is Secretary-Treasurer, with the following directors:

Mrs. W. R. Sutton, Blountsville, Woman's Division; and Max V. McLaughlin, M. D., Mobile, 1st Congressional District; Frank M. Phillippi, Jr., M. D., Brewton, 2nd; Robert J. McLaughlin, M. D., Ozark, 3rd; Richard F. Bliss, M. D., Talladega, 4th; John H. Nelson, M. D., Tuscaloosa, 5th; Julius N. Hicks, M. D., Birmingham, 6th; Ellis F. Porch, M. D., Arab, 7th; Carl A. Grote, Jr., Huntsville, 8th; and the following ex-officio members:

Mrs. Benjamin H. Johnson, Jr., Bessemer, president, Woman's Auxiliary; Mrs. Howard C. Johnson, Sheffield, president-elect; C. Kermit Pitt, M. D., Decatur, MASA president; and John M. Chenault, M. D., Decatur, chairman, State Board of Censors.

William J. Mahoney, Jr., Montgomery, is Executive Director of ALAPAC. And also attending the September meeting was Mrs. Fred Reynolds, Montgomery, ALAPAC bookkeeper.

The board looked over the significant highlights of the late Legislature as they affected Medicine, decided to broaden the scope of its activities, and will fill in the details at its November meeting.

The Use Of Prisoners For Drug Trials In Alabama

(Editor's Note: This report of a special committee appointed to study the drug-testing program in Alabama prisons is published in its entirety upon suggestion of the AMA Judicial Council, as approved by the Board of Censors of MASA).

Introduction

Statement of the Problem: It has been well said that while conflict between right and wrong is melodrama, conflict between right and right is tragedy.

It is right that the health of the public be protected by drug testing. Following extensive animal experimentation, such as that now being conducted by (or for) all of the ethical manufacturers of pharmaceutical products, there inevitably arrives the time when someone has to be the first human to receive the new drug. We strongly endorse the policy of the Food and Drug Administration which insists that in most instances the someone be, not an enfeebled, sick man, but a healthy human volunteer. Who should that volunteer be? We shall shortly return to that question.

It is also *right* that every precaution be taken to safeguard the health of the prison inmates. We believe that this has been done in principle and in policy but that under the existing circumstances, it has not been possible to do so in detail.

At first glance, it may seem that there is an inevitable conflict between these two "rights." The major effort of this committee has been directed toward this dilemma. In this effort, we have been aided by the complete support of the governing body of the Medical Association, and by the cooperative attitudes of the Food and Drug Administration, of the State Health Officer, the *Montgomery Advertiser*, the members of the Board of Corrections, the Commissioner and staff of the prison system, the representatives of a number of leading pharmaceutical manufacturers, and of a variety of consultants from inside and outside our State. We wish to thank these groups and individuals. Without such support and cooperation, it would probably have been impossible for us to arrive at any practical conclusions and recommendations.

Background Information

It appears that the Southern Food and Drug Research, Inc., has been operating a research program in the Alabama Prison System since 1962 with the approval of the Commissioner of the Alabama Board of Corrections. The president of Southern Food and Drug Research (known between 1963 and 1967 as JEMCO, Inc.) is a graduate of the University of Oklahoma and of the Medical College of the University of Tennessee. He conducted research programs in the Oklahoma prison system and the Arkansas prison system before coming to Alabama. The physician for Kilby Prison is also associated with Southern Food and Drug Research.

The original emphasis for Southern Food and Drug Research was on a plasmapheresis program but this was discontinued in 1964 following an outbreak of hepatitis which involved 376 prisoner participants with three deaths. (A Public Health Service investigation showed that the outbreak was definitely linked with the plasmapheresis program and a significant break in aseptic technique was found which accounted for this.) In 1963, however, the Food and Drug Administration set for the various drug houses much stricter standards for drug testing and these included a greatly increased demand for Phase I testing (Phase I testing is that done on healthy humans after completion of the animal experimental work). As a result, proficient investigators with adequate facilities were in considerable demand and Southern Food and Drug Research then concentrated its attention in this area.

Over the years since then, the drug houses seem to have been generally satisfied with what was done in Alabama and the Food and Drug Administration has had no specific complaints although they queried the number of investigations being done at any one time as being perhaps too many for adequate medical supervision by the limited medical staff of Southern Food and Drug Research. Internal control over the program by the Board of Corrections and its officers appears to have been limited in amount with the Medical member of the Board briefly reviewing the protocols for each new drug trial and occasionally mentioning them to members of the Board.

Membership on the Board of Corrections is not a full-time position. With their primary interest to attend to, it could not be expected that members of this Board be completely and constantly aware of every transaction affecting the prison system at a given time. A busy physician could not devote the time required to properly evaluate the protocols without neglecting his private patients.

The Commissioner and his wardens apparently gave the drug testing group ready cooperation with very few questions being openly asked. The prison physicians for the other two prisons involved in the drug testing program (Tutwiler and Draper) generally required that they be kept advised of new drug testing programs in their own prisons when these were initiated.

While most of the work done by Southern Food and Drug Research was for private drug companies, other programs were occasionally undertaken for agencies such as *NASA* and on a subcontracting basis for the Medical College of Albany, New York. Conversely, a very limited use has been made by the University of Alabama Medical Center of prisoners for drug trials and the Red Cross has, at infrequent intervals, taken blood from prisoners.

In January, 1969, the *Montgomery Advertiser-Journal* launched a series of attacks at the drug testing program being conducted in Alabama prisons. In addition to hinting at excessive profits being made, at the expense of the health of the prisoners by Southern Food and Drug Research, certain additional medically oriented accusations were made:

1. Although the inmates signed a waiver they were not told of the possible effects of tests while the prisoners' strong need for extra money largely invalidated the requirement of informed consent.

2. Physical examinations were not being performed before each program as required in some protocols.
3. A doctor was not present during many of the potentially critical periods of reaction.
4. Some of the experiments left the men too sick to perform their regular duties.
5. Prison inmates drew blood and performed other technical procedures.
6. The contrast between the facilities for the private concern's testing program and the extremely inadequate facilities available for treating sick prisoners was shocking.
7. A number of quite serious reactions had occurred among prisoners but these had received little attention.
8. The administration of the program with prisoners sometimes, giving false histories and not taking the medicine provided for them, made the results of the testing program somewhat unreliable.

The newspaper articles were not entirely negative and they did point out that needed research was carried out, inmates did receive money to buy cigarets and other needs, and the Prison Welfare Fund received some monies which could be used for programs that the State did not provide. (At Kilby and Draper 20 per cent of the money paid to the prisoners went to the Prison Welfare Fund). The newspaper suggested that the entire program be placed under the authority and supervision of the University of Alabama Medical School, that the participants be properly remunerated, that profits from the program should go for improvements in the prison system, that the testing program be so scheduled as not to interfere with the work or training at the prison, that the participants be clearly informed of possible dangers involved in the program, that the controls over the program provide for good scientific evaluation and that good medical supervision be exercised at all times.

Following this adverse publicity which carried distinct connotations of laxity on the part of the Board of Corrections and possible dishonesty on the part of certain of their senior employes, the Board of Corrections adopted the following resolution.

> "That the Chairman be authorized to appoint a committee of two or more persons qualified to determine from a medical standpoint, and not connected with the Board of Corrections, to investigate any drug testing programs conducted in the State Prisons, to determine whether the programs are properly supervised to protect the health of the participants, both in testing and in the event of any after effects of the testing, to determine whether any prisoners are being abused in any way, and to report to the Board their findings."

Upon receipt of this request, this committee was appointed by the governing body of the Medical Association. This report constitutes our findings.

Findings

The findings of the Committee may be summarized under the following headings:

1. Prison testing facilities.
2. Equipment and staff (Southern Food and Drug Research).
3. Drug house relationships.
4. The situation in other states.
5. The present medical program (Alabama Prison System).
6. Errors of fact.

1. Prison Testing Facilities

Kilby, Tutwiler and Draper Prisons were visited during the course of the investigation. Private conversations were held with the three wardens, the three prison physicians (two of these were seen elsewhere than in the prison for which they were responsible), the president of Southern Food and Drug Research, the staff providing medical care in the three prisons, technicians involved in the testing program, and a number of prisoners who were on or had been on one or other of the testing programs together with a number of more junior prison officials.

At Kilby Prison a list was seen of prisoners who had been selected by Southern Food and Drug Research from their records as being suitable subjects for a new test which was being started that morning. No person in the prison system had any hand in selecting this initial list. From about 60 names which had been submitted, the warden had deleted about ten because, so he advised us, these persons could not be spared by their division heads from their official prison occupation. Most of the remaining 50 prisoners had been called into the testing room in the prison that morning in groups of about six persons. While blood was being taken from them (apparently for laboratory testing) they had received a rapid explanation of the purpose of the test, (there was considerable variation in the understanding of what had been said) with the statement that the drug being tested was safe and should the laboratory tests be satisfactory, they would be asked to sign a waiver-consent form. All this had seemingly been done by technicians with no physician being present as far as could be determined. Two of the four prisoners who were interviewed indicated that they had never been examined by a physician while they were in the prison although they had been on several drug trials. One of these prisoners told of tests with an anti-hypertensive drug which had had to be discontinued after three weeks (the trial was supposed to run for four weeks) because of severe reactions among those taking the pills. He himself had hung on to the end although he had been feeling very ill and had not complained of this illness, because it would have meant his losing the pay which he was hoping to receive for his participation. The majority of the prisoners interviewed indicated that the only reason they participated in the drug trials was because of the money which they were paid.

At Kilby, the original medical screening of convicts and the treatment of those who fell ill appeared to be largely in the hands of a man with very little previous medical training. His prior experience before entering his present position had been that of a venereal disease inspector. This man is supplemented in his duties by a number of part-trained inmates who are used as orderlies. It was stated, with pride, by this individual who functions as hospital director that he himself was able to deal with nine out of every ten patients who came to him so that the doctor was not bothered. It is apparent that he has been permitted to usurp responsibilities far in excess of his qualifications. It has been learned that this individual is responsible for the filling of requisitions for drugs from the other prisons within the system. In this capacity he has made substitutions for the drugs requested. Such decisions should be made by a licensed physician. It is

apparent to this committee that with proper controls this situation could not have existed.

Conditions in the so-called hospital at Kilby were appallingly bad and would not have been acceptable 50 years ago, let alone today. One felt that a little extra effort and a little additional money would have made a tremendous difference if only the drive had been there. The importance of this hospital at Kilby is that it turned out later that persons having severe reactions to any of the drug trials in any of the prisons were transferred to this hospital for more intensive care.

The situation at Tutwiler Prison where only women are housed was immeasurably better than at Kilby. Both the warden and the hospital matron knew what was going on and had details of each protocol in front of them. Only relatively innocuous drugs such as certain hormonal products were tested at Tutwiler (the potentially dangerous drugs were tested at Draper and Kilby where only men are housed). The subjects in each trial knew the purpose of the trials and reported regular and adequate supervision. Housing and care were generally satisfactory and the morale of staff and prisoners was obviously high. It was notable that these prisoners received a larger weekly allowance than was the case in the other two prisons and appeared to make good use of this. We were told with pride by the prisoners of patients with cancer, which had been diagnosed early as a result of the testing program and that these patients were now receiving proper treatment. The difference in this prison was more than could be accounted for by the nature of the trials being undertaken, or by the fact that this was a woman's prison.

The situation in Draper was similar to that which had been found at Kilby, though not as bad. The difference was probably related to the dedication of the prison physician and to the strong sense of responsibility of the warden. There was no question here but that inmates had been used as technicians until very recently, while severe drug reactions were not being given the attention (medical or experimental) which their condition deserved. Supervision for patients who had been "stopped up" in the special room constructed by Southern Food and Drug Research, appeared to be almost entirely non-medical in nature and no really adequate provision had been made for any serious, unexpected, severe reaction. Once again, it appeared that most of the prisoners were volunteering purely for monetary reasons and were staying on the tests even after disturbing reactions had occurred simply to be paid more. There was some question whether a physician was being called on to decide what reactions were serious enough to constitute a demand for a patient to be withdrawn from a trial or whether this decision was in the hands of a technician. Here also, it appeared that the drug trials were given priority over the normal business of the prison and this division of authority could hardly have benefited the status of the local prison officials who were doing, apparently, a good job under difficult circumstances.

Your committee believes that by and large, the research studies completed and published in highly respected journals by staff members of Southern Food and Drug Corporation represent creditable, useful, and practical contributions to medical science. However, this good should not be permitted to hide the manifest defects in the present system.

The Board of Corrections with its physician member has naturally assumed that any doctor conducting experimental studies on human subjects would take the utmost precautions to safeguard the health of such subjects. Their confidence has been gravely abused.

It is the opinion of the committee that the prison testing facilities in Kilby and Draper do not measure up to minimum standards and compare unfavorably with what has been described to us as existing in several other states (see later in this report). Within Alabama, the limited testing done on prisoners at the Clinical Research Center of the University Hospital provides a striking contrast to what was observed in Kilby and Draper. In this University program, a few prisoners were selected for good behavior and understanding of what was involved. They were housed in the same quarters where other non-prison volunteers were housed with no guards. None took advantage of the easy opportunity to escape and since discharge from the prison at least one former prisoner has revisited the Research Center to express his gratitude at being given this opportunity for moral rehabilitation.

This committee was confronted with a seeming conflict of interest when it viewed the dual role of a doctor serving as both senior prison physician and as an officer of Southern Food and Drug Research. He readily acknowledged that a potential conflict of interest could exist. This unconscionable situation, regardless of reason, should never have been permitted to come into existence. This situation places all persons concerned in an untenable position exemplified by the necessity for for the investigation.

2. Equipment and Staff (Southern Food and Drug Research)

The laboratory of Southern Food and Drug Research occupies the second floor of a building at 306 Arthur Street in Montgomery, Alabama. Space seems adequate and work tables, casework, shelves, record storage areas and equipment seemed sufficient for the work done. Reagents appeared fresh, were well labeled, and stored in an orderly manner. Major equipment consisted of microscope, large centrifuge, freezer, refrigerafor, flame photometer, water bath, spectrophotometer, P. H. meter, Coulter counter, and a dual channel autoanalyzer for doing several routine chemical procedures using several manifolds. Procedures determined with the autoanalyzer consisted of BUN, sugar, alkaline phosphatase, total bilirubin, total protein, and albumin. Several enzymes were being determined by manual methods. CBC's and urinalyses were done by routine methods including a Coulter counter for cell counts. The refrigerator contained Dade commercial control sera and some homemade pooled sera.

We examined a series of alkaline phosphatase and bilirubin values directly from the autoanalyzer chart paper and saw one set of standards and one control for about 20 unknown patient samples. The control was calculated from the chart and showed an error of about 40 per cent on the alkaline phosphatase. This was pointed out to the laboratory director and he excused it on the basis that commercial controls were sometimes wrong and that they could depend more on their own values. (In our experience this is occasionally true but it requires repeating the tests with other controls.) His attitude to us was unacceptable and reflected poor technique. The technician operating the analyzer on the day of our inspection had limited knowledge of the instrument.

All personnel were certified by American Medi-

(Continued on Page 401)

(Continued from Page 398)

cal Technologist which has limited significance in our opinion, but most had received military training in laboratory schools. These military programs are frequently quite good, and the laboratory director seemed well informed. We conclude that the laboratory is adequately equipped, staffed by people with minimal, if not marginal, acceptable training and results are generally but not always accurate. It probably compares favorably with many small hospital laboratories in Alabama but lacks the better qualified personnel and more careful quality control seen in better run laboratories.

Some tests such as Pap smears and PBI's have been done by the Pathologist-in-chief of the Montgomery Baptist Hospital for the past four years. He has given free consultation about laboratory procedures to Southern Food and Drug by personal contact and telephone on several occasions. Random samples of the other procedures have at other times been sent to his laboratory for comparison of results. Our conclusion that Southern Food and Drug operates an acceptable but not always reliable laboratory was shared by this pathologist who has privately recommended better supervision of the laboratory and indeed of the entire testing program.

3. Drug House Relationships

Reputable drug firms are concerned with developing and producing effective, safe medications. Their record in carrying out this function is unassailable. In their search for new therapeutic agents they maintain an impressive laboratory operation with a competent, highly trained research staff. All newly isolated or synthesized entities to be evaluated for drug potential are carried through an exhaustive battery of tests in several species of animal subjects providing toxicity data and general pharmacological profiles to serve as a basis for prediction of human responsiveness to the same agent.

The preclinical or animal work required of the drug developer is not specified in detail by the FDA and may vary within limits depending on the nature of the compound. The studies, however, must leave no "blind spots" in the animal pharmacology. It is generally accepted that the need of the manufacturer to intimately and thoroughly know his product and the responsibility of the FDA to protect the public from drug hazards is adequate proof that the manufacturer has done everything possible to provide, by animal studies, predictive information for use in human studies.

Regardless of the sophistication and exhaustiveness of animal studies, however, the definitive test of what the drug will do in the human is learned only by use in humans. The predictive value of animal studies is less than absolutely established. Litchfield, in a retrospective study of six drugs evaluated in laboratory animals and man, found inconsistencies but concluded that some predictive value could be shown. Phenylbutazone threshold difference between rabbit and man is more than forty fold. A compound shown by Brodie to anesthetize the rat satisfactorily so that infusion for eight hours was followed by complete recovery in 10 minutes was, in a careful study in the first human subject, found to require 48 hours for recovery after a 10 minute infusion. *Thus, there is inherent in the clinical testing to follow some usually small but inassessible hazard.*

It is reassuring to remember, however, that the compound's activity is in the physical and chemical properties of its molecule. A clinical pharmacologist thoroughly familiar with the physical and chemical nature of the drug and with appreciation of the fact that the body's ability to dispose of a drug often depends on an enzyme system with broad or narrow substrate limits, will be prepared for dealing with blood levels that might result from the human's not possessing a polarizing enzyme with spectrum broad enough to include it. Clinical testing should either be done by an investigator trained in clinical pharmacology who will recognize the importance of an intimate and thorough knowledge of the new and potentially hazardous test material; or there should be extensive conferences between preclinical and clinical investigators and not just a mere presentation of the animal data reports with the assumption that they will be read and perceived.

It is our opinion that Phase I studies, in general, and, in particular, those involving a first human testing, do not give sufficient importance to either the choice of the investigator or the briefing of the investigator. This is particularly relevant for agents of an entirely new action category or having a new chemical configuration. There is the impression often that protocols are passed to any available clinical investigator to be carried out in a routine stereotype manner. A clinical investigator may thus be doing a job in which he feels competent from having performed perfunctorily in the same capacity for many years but with very little understanding of the role he is performing. FDA and pharmaceutical manufacturer's monitoring is provided but this evaluation may be too superficial and too remote to provide maximum safety. Less than ideal Phase I testing inevitably increases the risk for those volunteers used in Phase II (the first testing on selected sick patients). In a recent discussion of a new drug product, a representative of Pfizer Laboratories remarked that . . . .

> For the early Phase II studies we want our investigators to be the most experienced available. Careful review of the literature and discussion with physicians at scientific meetings are important aspects in our investigator selection process. We selected four well-recognized experts in the field as our principal Phase II investigators. With these we discussed the experimental procedures to be followed and with collaboration of statisticians, designed the clinical protocol . . . . After pilot studies were completed we called our investigators together for a "think tank" type of discussion at which their results were received.

In contrast, the only mention of selection and briefing of Phase I investigators is that "two were selected."

In the present instance there is no reason to believe that the pharmaceutical firms failed to act in good faith or failed to discharge their responsibility to the general public to develop safe effective therapeutic agents. They contracted with approved clinical investigators to carry out approved research projects. However, there are some points for possible criticism, (1) There may have been a too superficial monitoring of the clinical work which they support, (2) They demonstrated some lack of discretion in selection of their Phase I investigator. Thus, there was a need to consider the number of projects to which the prospective investigator was already committed, (3) Their initial conference sessions may not have provided for adequate grounding of the investigator in all the significant basic properties of the test material, a particularly important point when the limited training in basic pharmacology

(Continued on Page 402)

(Continued from Page 401)

of both clinical investigators of Southern Food and Drug is considered.

That the drug manufacturers are interested in conducting and supporting research programs of quality is confirmed by a consideration of two clinical programs established and operated by two of the major firms, the Upjohn Company and Parke-Davis at the Southern Michigan State Prison. These programs involved an initial expenditure of perhaps one half million dollars for facilities and are generally believed to be first class, both in providing for optimum safety and welfare of the human subjects and in providing dependable clinical data.

There is no reason to doubt that excellent programs are desired by the drug manufacturers or that they would support such programs. Despite this, both the drug firms and FDA have given tacit approval to the research in Alabama prisons, an approval based on their confidence in the reliability of data so obtained. It should be noted, however, that neither is primarily concerned with the rights and welfare of the institutionalized research subject. There is within the body of the law some provision for protecting the welfare and rights of prisoners used as research subjects, but in the absence of sufficient funds and some watchdog mechanism, these rights may be abused. There is the justifiable view that the drug manufacturer is not abandoning any moral or ethical responsibility in assuming that the welfare of institutionalized human subjects used in testing its products will be adequately underwritten by the administrators of the institutions or by other state agencies, boards, or commissions charged with that responsibility. The states in which prison inmates are used as experimental subjects provide examples of very adequate provision for welfare of the human subjects through "human use" committees and "human experiment review boards" which are concerned primarily with protection of the human subjects. That, except at the Medical Center, there is no such firmly structured monitoring group in Alabama should not be considered to extend the responsibility of the drug manufacturer to assume this neglected duty. There is good reason to believe, however, that the pharmaceutical manufacturers would much prefer to have their clinical programs conducted under an officially supervised system in which the welfare of the human subject is assured.

The committee is of the opinion that drug companies would also prefer a system which would provide for on going "quality control" during a drug testing program and a certainty that all possible toxic reactions, whether real or only apparent were being fully reported. An agency which would establish clinical research standards and policies and critically assess the safety and propriety of all procedures and the conducting of these would serve the cause of drug research and the principle of individual rights.

In summary it may be concluded that the pharmaceutical firms are generally not subject to criticism for the present state of the clinical research program under investigation. They have contracted with approved clinical investigators to do approved research on compounds which they have developed and for which they have provided very thorough preclinical testing. That they may have been unwise in their selection of a clinical investigator is a point for criticism but is understandable. That they have not shown greater interest in the welfare of the subjects used in the clinical investigations is explicable since they would understandably assume that such an obligation would be underwritten by alert state agencies. There is evidence that the pharmaceutical firms would prefer to have their clinical research program conducted under a system by which adequate state provision for prison inmate welfare would be assured.

4. The Situation in Other States

During the course of this committee's work, a survey was made on the use of inmates for drug testing in the prison systems of other states. This survey was made by written inquiry to the commissioners or their counterparts of the 49 other prison systems. At the time of this writing 35 responses have been received.

Twenty states do permit drug testing within their prison systems. Fifteen states do not permit testing; however, the State of Tennessee has proposed legislation which would permit testing within the system there.

In those states where testing is permitted, their programs appear to be well structured along two main lines, in order to insure (1) ultimate protection of the health and safety of the human subjects and (2) minimum interference with the operational aspects of the prison itself.

The protective mechanism in most instances is centered around a professional committee which passes judgment on each testing program that is proposed. Such a committee then makes a recommendation to the prison board which must have final authority before testing can be conducted.

In these states without testing programs, the reasons, where given, for their non-existence were usually a lack of proper facilities and medical facilities in particular.

The one general area of agreement in those opinions expressed or inferable is that drug testing is essential. Further, the presence of drug testing programs in a prison affords another means of rehabilitation through the provision of a channel by which the prisoners can make both a humane and financial contribution to society and their families.

The programs in other states have far superior controls, both medically and administratively, to those presently found in the Alabama system. The relative lack of controls could well account for the vast amount of testing done in the Alabama system.

The appendix to this report contains examples of some procedures used in other systems which the committee feels have considerable merit.

5. The Present Medical Program (Alabama Prison System)

We believe that the physicians responsible for the health of the prisoners at Atmore, Draper, and Tutwiler Prisons have done a *magnificent* job when their work is considered in relation to the pitiful and almost scandalous lack of facilities, funds, and personnel available to them. At the expense of personal economic loss, lack of time with their families and almost complete sacrifice of opportunities for recreation and relaxation they have proven their dedication to the Hippocratic tradition. We applaud the degree of voluntary devotion, to their own concepts of their obligation to society, displayed by these three prison physicians.

Certain aspects of the various prison medical facilities have been described earlier in this report. They, with the exception of Tutwiler, are unacceptable. The Tutwiler dispensary while

(Continued on Page 404)

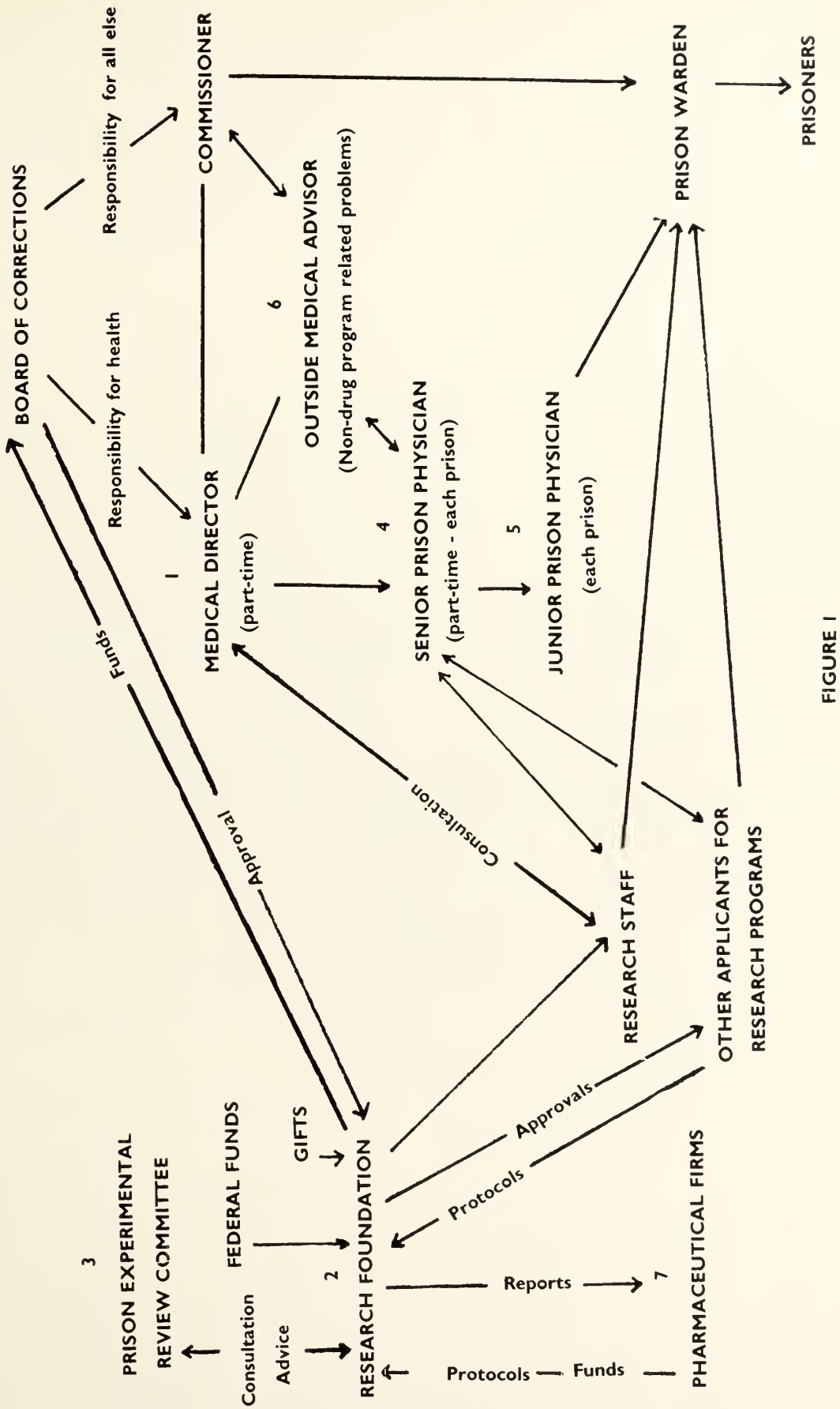

BOARD OF CORRECTIONS
Responsibility for all else
COMMISSIONER
Responsibility for health
1
MEDICAL DIRECTOR
(part-time)
6
OUTSIDE MEDICAL ADVISOR
(Non-drug program related problems)
4
SENIOR PRISON PHYSICIAN
(part-time - each prison)
5
JUNIOR PRISON PHYSICIAN
(each prison)
PRISON WARDEN
PRISONERS
Funds
Approval
Consultation
3
PRISON EXPERIMENTAL
REVIEW COMMITTEE
Consultation
Advice
FEDERAL FUNDS
GIFTS
2
RESEARCH FOUNDATION
RESEARCH STAFF
Approvals
Protocols
OTHER APPLICANTS FOR
RESEARCH PROGRAMS
Reports
7
Protocols
Funds
PHARMACEUTICAL FIRMS

FIGURE I

(Continued from Page 402)

superior to that in the other prisons, could be improved.

6. Errors of Fact

Respect for the Board of Corrections and for the Commissioner requires that the committee report that certain errors of fact did appear in the newspaper articles concerning the drug testing program. These include:

(1) The ownership of the ward constructed at Draper. This building is used by Southern Food and Drug Research, Inc. and was paid for by the corporation. It is now property of the Alabama Prison System.

(2) The "blood draws" allegedly taken at Atmore did take place, but these were donations to the American Red Cross. We were unable to confirm any plan to expand the drug testing program to the Atmore facility.

(3) At no time has an expansion of the testing program been planned to include the testing of foods. Southern Food and Drug Research, Inc. did offer (this offer was accepted) $7,000 toward the purchase of new kitchen equipment badly needed at Draper.

(4) No modern laboratory facilities were found to exist at any prison facility. The laboratory of Southern Food and Drug is in Montgomery.

It is not this committee's responsibility to pass judgment upon the motivation behind the printing of these stories. We do not believe these articles were errors of intent; however, they are errors of fact. The implications of some of these articles were not substantiated in this committee's findings.

Implications

Our investigations have shown substantial defects in the drug testing program as administered at present in Alabama prisons. This does not, however, change our opinion that drug trials using prisoners can and do serve an essential purpose. They benefit the Nation and provide the prisoner with an opportunity to contribute something back to society, to earn some extra needed money and to improve living conditions in the prisons through a well developed welfare fund. In addition, a well conducted drug testing program would provide extra medical coverage for prisoners with the possibility of the early diagnosis and treatment of disease and better diagnostic facilities than might otherwise be available. Actually this has frequently happened in Alabama.

Considering the present situation we regard it as being distinctly unsatisfactory. The prisoners' welfare is not being adequately safeguarded and the validity of the drug trials themselves must occasionally be seriously in doubt. The chief deficiencies are undoubtedly the lack of an adequately trained staff, the lack of sufficient interest in the prisoner as a patient, the lack of medical supervision, the unique pressure toward signing a "consent form" because of the need for money, unsatisfactory conditions for the treatment of those prisoners who do fall ill and the lack of any adequate peer review of protocols which are submitted. For the staff and facilities which are available, there is no question but that far too many trials are being conducted at the same time. Thus, at the time of our visit it appeared that no fewer than seven separate trials were being conducted in the three prisons we visited.

Faced with the present situation one is tempted to look back and ask "How did this happen?" It is not our intention, however, to rake over old coals, except where such a review might lead to improvements in the future. In general, we would comment that supervision over the program has been inadequate and the responsibility for this must fall to some extent on all senior administrative levels. Men, no matter how worthy, simply cannot do what they wish to do, without the needed funds. The work of Southern Food and Drug is unacceptable in terms of safeguarding the health of the prisoners. Others seem to have been involved more through innocent acceptance than through anything else. In retrospect it is easy to see that a request to the State Health Officer for an adequate control inspection might have saved a lot of grief, but this overlooks reality.

It is only right that prisoners, as wards of the state, should, *in the absence of a drug testing program*, receive medical care of the same general quality as that received by the average citizen of the state.

We believe that with very little help from the State, a sincere attempt has been made at Atmore prison to give this level of medical care. The dedicated physician providing this care has paid not only with time and at the probable price of his own health but, in part, out of his own pocket. It is totally wrong that a physician should, because of his own dedication, be forced to meet an obligation that should rest firmly on the shoulders of the tax payers of Alabama.

Where *there is a drug testing program* the obligation is different. Here the responsibility is to provide the quality of care that a volunteer ordinarily receives at a first class research institution. The fact that the volunteer is a prisoner does not alter this. Because there are fewer prisoners and because (see above) the drugs tested are relatively innocuous, the care of Tutwiler has been of high quality. Again the cost has been met in part from the pocket of a dedicated physician.

The situation at Draper is different in some respects and similar in others. There are many more prisoners, many more testing programs, and drugs that are far more likely to produce adverse effects are being tested. Despite the strong attempt and the out-of-pocket contributions of a third dedicated physician who, like the other two, has the full support of his warden, it has not been possible to provide the minimally acceptable standard of care that could probably have been provided had there been no testing program.

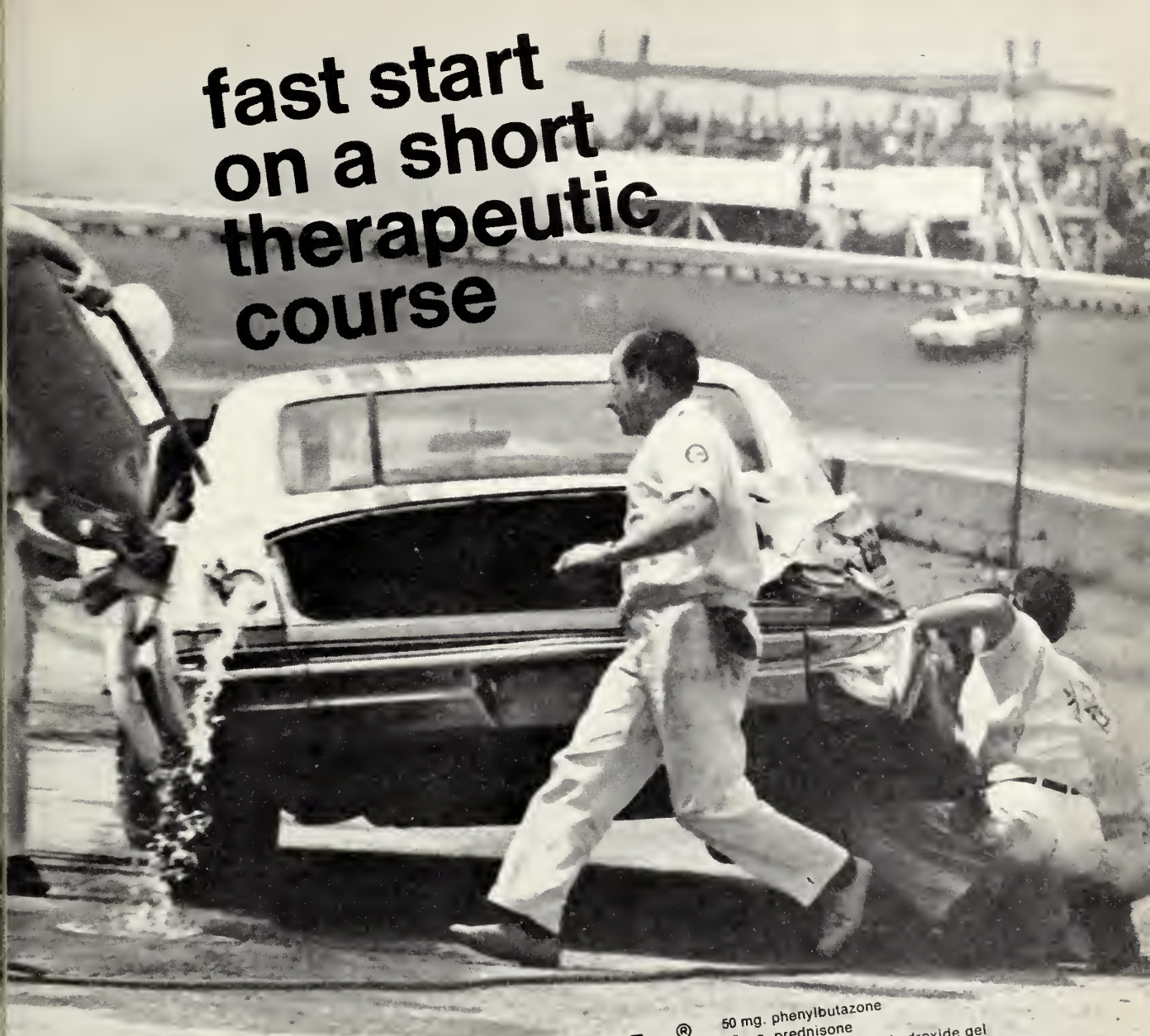
The responsibility for the greatly increased cost of a higher standard of medical care that should be a direct consequence of drug testing is not that of the taxpayers of Alabama. It is directly or indirectly the responsibility of the companies whose drugs are being tested. There is one large difference, the Alabama taxpayers have, as yet, shown no desire to meet their responsibility while the drug manufacturers have seemed willing to meet theirs.

We do not know what the expense of this difference between the cost of average quality health care without drug testing and superior care with drug testing will be. We are certain it will be substantial. Nevertheless, we have hopes that the drug companies will do their part.

It seems to us now that with the exception of the noted errors of fact and their perhaps graver errors of implication the *Montgomery Advertiser* was correct in most of its criticisms of the present drug program. There were insufficient controls

(Continued on Page 408)

fast start on a short therapeutic course



Sterazolidin®

50 mg. phenylbutazone
1.25 mg. prednisone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

Prompt anti-inflammatory action for...
relieving pain and stiffness
reducing tenderness and swelling
restoring joint movement
in bursitis, synovitis, tenosynovitis
and acute fibrositis.

Total treatment time: 7 days
Usual dosage: 2 capsules t.i.d.

erazolidin is valuable in the treat-
nt of acute rheumatic conditions so
en refractory to routine therapy.
wever, it is a potent drug, not a simple analgesic. Therefore, Stera-zolidin should never be administered casually. For complete details on dosage, adverse reactions, contrain-dications and precautions, please see the following two pages.

Sterazolidin®

Each capsule contains:

Butazolidin®, brand of phenylbutazone	**50 mg.**
prednisone	**1.25 mg.**
dried aluminum hydroxide gel	**100 mg.**
magnesium trisilicate	**150 mg.**

Antiarthritic
Anti-Inflammatory

Capsules

Important Note Butazolidin, brand of phenylbutazone, and prednisone, the active ingredients of Sterazolidin, are both potent drugs; the pharmacologic action of each should be borne in mind when Sterazolidin is prescribed. Sterazolidin combines anti-inflammatory, analgesic, antipyretic, and antiallergic properties and cannot be considered a simple analgesic and should never be administered casually. The usual warnings, precautions and contraindications associated with Butazolidin, brand of phenylbutazone, therapy and steroids apply to Sterazolidin.

Indications: *Chronic treatment of:* rheumatoid arthritis, rheumatoid spondylitis, osteoarthritis; and also treatment of acute rheumatic conditions such as bursitis, synovitis, tenosynovitis, various forms of acute fibrositis, and acute gouty arthritis.

Contraindications
Usually absolute: active, questionably healed or suspected tuberculosis, herpes simplex ophthalmia, acute psychoses or severe psychoneuroses, history of blood dyscrasia, the frankly senile patient, and active peptic ulcer.

Relative: exanthematous diseases, particularly varicella and fungal diseases (for other viral diseases, the physician must weigh the possible undesirable effects against anticipated clinical improvement), diverticulitis, recovery phase after gastrointestinal surgery, any condition complicated by cardiovascular disease, renal insufficiency, moderate or severe diabetes mellitus, thrombophlebitis, osteoporosis, convulsive disorders, thyroid disease, history of drug allergy, history of peptic ulcer, hypertension, the elderly patient, psychotic tendencies, pregnancy, except in severe disease (the safety of Sterazolidin in pregnancy has not been established), edema, and hepatic damage.

Its use in conjunction with other potent chemotherapeutic agents may greatly increase the possibility of toxic reaction, and this practice is, therefore, inadvisable. Large doses are contraindicated in patients with glaucoma.

Warning Coumarin-type anticoagulants depress prothrombin activity. This is accentuated in some cases when Butazolidin, brand of phenylbutazone, is simultaneously employed in treatment; occasional instances of severe bleeding have been reported. Patients receiving coumarin-type anticoagulants should be very carefully followed for evidence of excessive increase of prothrombin time when Sterazolidin is added to this regimen. Anticoagulant therapy can then be properly adjusted, if necessary. When prescribed alone, Sterazolidin has not been shown to influence prothrombin activity. Persistent or severe dyspepsia may be indicative of peptic ulceration. In these instances, upper gastrointestinal x-ray diagnostic tests should be performed if the drug is continued. Pyrazole compounds, such as phenylbutazone, may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Patients receiving such concomitant therapy, therefore, should be carefully observed for this effect.

Precautions and Adverse Reactions *Gluco-Corticoid Activity:* In some diabetic patients on prednisone, the insulin requirements may be increased. It is advisable to observe diabetic patients carefully during the treatment period. Since gluco-corticoids may unmask latent diabetes, all patients should be observed for this effect.

Electrolytes: Many patients receiving prednisone in average amounts show some loss of sodium, with little or no loss of potassium. With continued high dosage, however, sodium retention and potassium loss have been observed. Butazolidin, brand of phenylbutazone, has a definite tendency to produce sodium retention and hence, edema, particularly in the older age group. Elderly patients or those with hypertension, cardiac defect or renal dysfunction should therefore use Sterazolidin with special caution and the drug should be discontinued if edema develops. Developm of edema may be prevented or minimize withholding salt from the diet. Sodium r tion may be counteracted with oral diur

Nitrogen: With the recommended dosag Sterazolidin, the possibility of nitrogen l remote. However, it is recommended th tients receive adequate protein in their Osteoporosis or spontaneous fractures occur with prolonged use of prednisone

Gastrointestinal Tract: Clinical and anir studies do not indicate that the ulcerog activity of prednisone or Butazolidin, br phenylbutazone, is enhanced in the com tion. To overcome gastrointestinal disc and occasional eructation in sensitive p the medication is best taken at mealtim with milk; Sterazolidin contains antacid ponents to minimize the incidence of ga complaints. All patients should be warn report immediately the occurrence of bl tarry stools. The development of anemia immediately suggest gastrointestinal bl

Blood Elements: Patients receiving prec exhibit an eosinophil response similar t seen with other steroids. During the init weeks of treatment, Butazolidin, brand phenylbutazone, usually causes some d of hemodilution and resultant lowering red cell count. This phenomenon does r represent a true anemia and is not indic of intolerance, but must be distinguishe true anemia secondary to gastrointestin bleeding or other causes. With the exte use of Butazolidin, brand of phenylbuta rare cases of agranulocytosis have occ (ratio less than 1 per 200,000 patients). I should also be noted that agranulocyto occur suddenly in spite of regular, repe normal white counts. Several cases of l kemia and leukemoid reactions have be reported with Butazolidin, brand of phe butazone, therapy. Although these reac cannot be definitely attributed to this dr possibility of a causal relationship can excluded. It should also be recognized arthritic-type pains are sometimes the f ing symptom of leukemia. Accordingly, patients receiving Sterazolidin should h

It's aggressive against acute arthriti pain and inflammation.



And, we want you to know all about

periodic blood counts before and therapy. Any unexpected, significant in the total white count, relative de- in granulocytes, or appearance of ure forms should be regarded as a signal mediate cessation of therapy and institu- appropriate countermeasures. Thrombo- nic purpura and aplastic anemia must considered possible side effects of with Butazolidin, brand of phenyl- ne.

Surgery: Prolonged use of prednisone use a potentially critical degree of cortical insufficiency which may persist ter cessation of prednisone therapy. re, if a patient is subjected to signifi- ess, such as surgery or trauma, either Sterazolidin therapy or within one year ssation of therapy, it is advisable to ster additional steroid and/or ACTH for ation of the stress. Delayed wound may also occur in patients on pro- therapy.

ns: High or prolonged doses of one interfere with the usual immune isms against bacterial and viral infec- d may promote their dissemination. In steroid treatment should not be given esence of infections unless appropri- iotic therapy is instituted at the same stemic and localized infection compli- during hormone therapy have been ob- including fulminating pneumonia, osis, moniliasis and aspergillosis. ntercurrent infection develop, indi- tibiotic therapy must be initiated y. Every patient who is to receive idin for any length of time should be nly examined, including chest x-ray, esence of pulmonary or extrapulmo- erculosis.

al Imbalance: Gluco-corticoids, in pro- osage, may cause manifestations of rtisonism or Cushing's syndrome, such face, abnormal fat deposits, mental nces, muscle weakness and atrophy, s striae, acne, ecchymoses, hirsutism, al disturbances, edema, osteoporosis taneous fractures, and hypertension. suppressing adrenocortical function, rednisone therapy may cause some f atrophy of the adrenal glands. There- terazolidin is to be discontinued, the osage should be tapered off gradu- ally. In addition, it may be advisable to stimulate the adrenal glands with ACTH. Prednisone induces a prompt decrease in the urinary 17-ketosteroids. Pretreatment levels are usually regained within 7 to 14 days after cessation of therapy. Under conditions of long-term administration, a small percentage of patients on phenylbutazone may develop varying degrees of reversible thyroid hyperplasia.

Allergic Response: Development of drug rash should alert the physician to promptly discontinue the drug. The presence of prednisone in Sterazolidin may reduce the degree of allergic response; nevertheless, the same cautious attitude must be preserved with Sterazolidin as with Butazolidin, brand of phenylbutazone, if allergic manifestations occur. Other adverse reactions that have been observed with glucocorticoid therapy include: excessive appetite and weight gain, hyperidrosis, pigmentation, dry,scaly skin, thinning scalp hair, tachycardia, thrombophlebitis, headache, neuropathy (including paresthesias and neuritis), diffuse vasculitis similar to periarteritis nodosa, subcapsular cataracts, impaired renal function, lupus erythematosus-like changes, convulsions, insomnia, abdominal distention, aseptic necrosis of the femoral head, acute pancreatitis and ulcerative esophagitis.

Miscellaneous: Stomatitis and, rarely, salivary gland enlargement occasionally require the interruption of treatment with Butazolidin, brand of phenylbutazone. Adoption of a lower dosage schedule and the institution of strict oral hygiene sometimes prevent recurrence of lesions. The infrequent occurrence of such subjective sensations as vertigo or languor during therapy with Butazolidin, brand of phenylbutazone, is seldom a serious or significant complication. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis and jaundice, hypersensitivity angiitis, pericarditis and several cases of anura and hematuria. Patients should be carefully evaluated before treatment is started and those receiving Sterazolidin must remain under close medical supervision to guard against undesirable reactions such as those described. They should be instructed to report immediately the occurrence of fever, sore throat, lesions in the mouth, or black or tarry stools. It is recommended that periodic examinations of the patient include:

1. Verbal and physical examination, including blood pressure and appraisal of the cardiovascular, digestive and skeletal systems, for indications of toxic reaction.
2. Complete blood count (at weekly intervals during the first month), urinalysis, x-ray and electrolyte studies, as indicated.
3. Check of patient's weight to detect significant water retention.

Dosage Dosage should be individualized. The following general rules should be observed:

In acute therapy, dosage *should not exceed* 12 capsules on the first day and 6 to 8 capsules on succeeding days. Treatment for more than 7 days is rarely necessary. When therapy extends beyond one week, dosage should not exceed 6 capsules a day.

In chronic therapy, dosage *should not exceed* 6 capsules a day and should be tapered off gradually to establish the minimum maintenance level at which the patient still feels reasonably comfortable. A trial period of one week of therapy is considered adequate to determine the therapeutic effect of the drug. In the absence of a favorable response, therapy should be discontinued.

When switching from chronic high steroid therapy to Sterazolidin, the importance of gradual reduction of steroid dosage cannot be overemphasized. It should be kept in mind that the steroid content of 8 capsules of Sterazolidin will replace 10 mg. of prednisone (or its equivalent in related steroids).

Clinical experience indicates that most patients with rheumatoid arthritis may eventually be maintained on 3 to 6 capsules of Sterazolidin a day. It is advisable to administer the total daily requirement in divided doses.

Availability Sterazolidin: Light blue and orange capsules, in bottles of 100 and 1000.
(B)46-660-B

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502



(Continued from Page 404)

over the drug testing program in allowing Southern Food and Drug a free hand within the prison system. The responsibility for this omission of controls to protect the prisoners must rest by virtue of their authority ultimately on the Board of Corrections. But we repeat that no man or group of men can possibly meet a responsibility that requires funds when they are not provided by the State with even minimal necessary funds.

Alternatives

As the problem has been described, we are faced with the dilemma of "right" versus "right." It is certainly "right" that new drugs should be evaluated before release to the general public, it is "right" that this evaluation should be meaningful —that is, it should be done in a thorough, scientific manner by competent individuals. It is "right" that the individual who is to participate in the trial (whether he is a prisoner or not) should do it purely on voluntary basis with full knowledge of the hazards involved.

In this area we are to be guided by the principles outlined in the Nuremberg Code, the Declaration of Helsinki, and the American Medical Association's Ethical Guidelines for Clinical Investigation. It is "right" that the prisoner with few rights of any kind should receive at least the average medical care available to free citizens, and be protected from those who might abuse his position and sometimes his ignorance to the detriment of his health for experimental purposes. It is certainly good if not right that prisoners be given a chance to earn some money (especially considering the pittance they receive otherwise in the Alabama Prison System). It is also good that prisoners so motivated may enhance their self esteem by making a positive contribution to the general public welfare by participating in a medical research program. (Our interview with those members of the faculty of the Medical College who have tested drugs on prisoners, shows that a well-run program by properly motivated people may have a definite rehabilitative benefit to the prisoners in their ability to relate to the free society.)

If there is so much right and good about the program, then what is our problem? Just as it is good that a well-run private enterprise such as A. T. and T. runs a superb telephone service in most of the United States, it is also right that such a monopoly should be regulated for the benefit of the customer who has no choice. By the same reasoning the highly desirable drug testing program might be well run by reputable free enterprise (such as ethical drug firms presumably do in Michigan) or by nonprofit research organizations as long as the research is monitored adequately by the officially designated commission or regulatory board. There are, however, certain practical problems which make such a free competition system awkward. These stem from the necessity that a unit capable of conducting such research establish major facilities such as clinical laboratories, research laboratories and offices in the vicinity of the research site and maintain a staff of highly qualified, carefully selected personnel. This constitutes a highly specialized functional unit, the existence of which would be without purpose in the absence of contracts for research. It is doubtful that even an altruistic private organization would be willing to make such investment without assurance of continuing contracts. If there was such, a free competition system would seem impractical or would likely revert to a monopoly system which would be subject to criticism.

A foundation established by a state institution such as a major university would be a logical alternative. Such a foundation would serve as a functional unit with laboratories and other necessary fixed facilities and with clerical and administrative staff directed by a clinical pharmacologist qualified to conduct human drug research. This foundation would be under control of a board of appointees qualified in medico-legal aspects of human experimentation, with the foundation director serving as permanent chairman. The controlling board would be charged with the responsibility of reviewing all protocols from pharmaceutical firms, or others submitting clinical research projects, assessing hazards inherent in the projects and critically evaluating the safeguards to be provided. The controlling board would also be responsible for seeing that all research subjects were aware of hazards and entered the programs voluntarily.

To protect themselves from any possible imputation of a "conflict of interest," the controlling board of the responsible foundation might advantageously appoint a Prison Experimental Review Committee to advise them on any potential risk to the health of the prisoners. The members of this Committee should not be related to the research foundation and might include a competent practicing physician appointed by the Board of Censors, a lawyer nominated by the Attorney General, and a designee of the State Health Officer. Since our suggestion does not envisage a monopoly for the responsible foundation (though the bulk of research invstigations would be channeled through them) the proposed Committee could also advise with regard to other groups which wish to conduct their own research in the Alabama prison system.

Moving from the general to the specific, the two major university-related non-profit organizations in Alabama which might fittingly establish the research foundation to which we have referred, are the Auburn University School of Pharmacy and/or of Veterinary Medicine and the University of Alabama Medical School. The authorities of the University of Alabama Medical Center and Medical School have, however, stated that directing and operating such drug testing programs is not within their sphere of interest. On the other hand, they would be happy to do all that they reasonably could do to aid in providing proper medical care to the prisoners and in protecting them from the possible harmful effects of drug testing. Preliminary discussions with Auburn University have been encouraging since this University has all the necessary potential and excellent leaders. This committee thanks both universities for the interest and attention they have given to this matter.

We are thus suggesting that all research protocols from drug companies and others be submitted to a new research foundation (hopefully sponsored by Auburn University) which would review these protocols.

After approval by the Foundation Controlling Board (with advice from the Prison Experimental Review Committee) the Board of Corrections would consider the proposal from the point of view of prison organization; and if they approved, submit it to the Medical Director and Warden of the prison in which the experiment is to be conducted. Any one of these groups or individuals would have the right to reject the program with *written* justification for their decision. (This might reduce the number of programs or participants from the present excessive level, but it

(Continued on Page 411)

"anorectal disorders"



This Rectopath Model
may help you explain
certain anorectal disorders
to some of your patients.
It is yours on request.

See next page for details.

"anorectal disorder"

includes a range of problems. For symptomatic relief in some of these disorders consider a member of the Anusol Family...

One suppository morning and evening and after each bowel movement.

ANUSOL®

soothing, palliative relief of minor pain, itching, burning, and other associated discomforts.

Each ANUSOL suppository contains bismuth subgallate (2.25%), bismuth resorcin compound (1.75%), benzyl benzoate (1.2%), Peruvian balsam (1.8%), zinc oxide (11.0%), and boric acid (5.0%), plus the following inactive ingredients: bismuth subiodide, calcium phosphate, hydrogenated vegetable oil, and coloring in a cacao butter and white wax base.

One suppository morning and evening for 3 to 5 days.

ANUSOL-HC®

prompt reduction of inflammation plus the soothing effects of regular Anusol.

Each ANUSOL-HC suppository contains, in addition to the regular Anusol formula, 10 mg. hydrocortisone acetate.

Precautions: Prolonged use of Anusol-HC might produce systemic corticosteroid effects.

One suppository every 3 to 4 hours, or every 2 hours if symptoms are severe.

ANUGESIC®

when severe pain requires prompt relief, pramoxine HCl plus the soothing Anusol formula.

Each ANUGESIC suppository contains: 61 mg. bismuth subgallate, 47 mg. bismuth resorcin compound, 32.4 mg. benzyl benzoate, 48.6 mg. Peruvian balsam, 300 mg. zinc oxide, 135 mg. boric acid, and 25 mg. pramoxine hydrochloride. Also contains the following inactive ingredients: bismuth subiodide, calcium phosphate, white wax, benzoinated lard, hydrogenated vegetable oil, and certified coloring in a cacao butter base.

Precautions: If idiosyncratic reaction occurs, discontinue medication.
Symptomatic treatment should not be allowed to delay definitive diagnosis and therapy.

Also available: ANUSOL® OINTMENT AND ANUGESIC® OINTMENT



The Rectopath Model is available from your Warner-Chilcott representative or upon request from Warner-Chilcott Labs., Morris Plains, New Jersey 07950.

Warner-Chilcott Laboratories, Morris Plains, N. J.

IN-91-4C

(Continued from Page 408)

would introduce adequate safeguards for the health of the prisoners.)

Obviously such a proposed system of controls would require considerable changes in its present operation. In a free enterprise system properly regulated it would have every right to submit its programs to the research foundation for consideration. Other interested parties might do likewise. No firm or individual should hold an exclusive contract to conduct experiments within the prison system. Each would be judged on its merit, safety and efficacy.

We are assuming, however, that in the vast majority of instances the research foundation would be asked not only to review the protocol, but also to undertake the research envisaged in the protocol. It would seem reasonable to assess the firms submitting research projects not only for direct costs, but also to cover the costs of the additional safeguards to the prisoners (including those of the Prison Experimental Review Committee)required by the research foundation and the Board of Corrections.

Pursuant to an amendment of the initial request made by the Board of Corrections, this committee has considered what it believes to be suitable alternatives to the present drug testing procedure in whole—or certainly in part—where needs are apparent.

These suggestions have been incorporated in Figure 1. Admittedly, both planning and money will be needed to implement an ideally structured program. The numbered items are discussed further in the text of this report, following immediately after Figure 1.

(1) As we see it the chief problem that may stem from the lines of responsibility and of authority that are illustrated in the diagram (Fig. 1) included in this report relates to the Medical Director.

Should the Medical Director for the entire prison system of Alabama be directly responsible to the Board of Corrections or indirectly through its highly respected Commissioner? There are obvious potential advantages and disadvantages in each method. We believe that this is a decision that only the Board should make. However, since it is our present impression that the Commissioner would prefer not to assume any responsibility in health matters, the diagram as presently drawn, indicates direct responsibility of the Medical Director to the Board. Obviously, the Board should have complete authority to make any changes it wishes as regards such an arrangement. We are suggesting that the Medical Director be part-time but that a substantial part of his income come from the Board of Corrections. He should receive no direct payment from any research group.

(2) The Research Foundation has been discussed elsewhere. The Foundation would share with the Board of Corrections the responsibility for obtaining funding which would make adequate supervision of all drug testing programs in the prison system a reality.

(3) The Prison Experimental Review Committee has also been discussed elsewhere. It is essential that this Committee take an active interest in what is happening and not degenerate into a rubber-stamp mechanism giving approval as a matter of form.

(4) The Senior Physicians for each prison would continue as at present to be part-time, but an increased remuneration is strongly recommended. It is proposed that this be achieved by augmenting their salaries by additional funds received indirectly (see later in this report) from the Research Foundation through the Board of Corrections.

(5) It is contemplated that the Junior Physician would be a resident on leave from a medical center for one year. This doctor would be paid by the Board of Corrections an adequate salary plus the benefits accorded other full-time prison system employees. An additional sum of money would be placed in escrow with the academic institution or hospital from which he is on leave to supplement his residency stipend during his final period of study.

(6) We have noted earlier in this report that the University of Alabama Medical Center has volunteered to do all that they reasonably can to aid in seeing that prisoners get proper medical care. This committee recommends that the Department of Public Health and Epidemiology at the Medical Center be asked to name a medical advisor to the prison system who would be outside the prison system. In addition to advising on the delivery of medical care, he could advise on matters of public health, communicable diseases, sanitation and the relative importance to be attached to health expenditures in a limited total budget.

(7) We have indicated earlier that the responsibility for the greatly increased cost of a higher standard of medical care that should be a direct consequence of drug testing is not that of the taxpayers of Alabama. It is suggested that the Board of Corrections (with appropriate advice) determine an estimated total cost for providing this extra care and that this cost, through the Research Foundation, be debited back to those drug firms making use of the Alabama Prison System for drug testing. It seems possible to the Committee that this cost might well be more than the present total cost of providing medical care in the prison system.

It must be emphasized that if this arrangement was achieved, this would not relieve the prison system of its own financial responsibility for providing acceptable medical care to prisoners. Indeed, this should provide a stimulus for much needed improved support from within the prison system.

Summary

It is the unanimous opinion of this committee that the drug testing program is almost essential and should be continued for the benefit of the prisoners and society in general. However, as presently conducted the program does not provide adequate safeguards for the health of the prisoners and leaves something to be desired in quality of results obtained. In order to alleviate these problems, we have made suggestions for certain structural and organizational changes in the program which should produce a system for drug testing that might serve as an example for the nation.

Early in our report, we likened our task to that of observing and commenting upon a "play" in a theater. Perhaps it is not inappropriate to pursue that analogy.

It has been our privilege to sit on the front row. We have observed a drama that has displayed certain minor aspects of comedy and many features of melodrama. But the major impact has been that of tragedy. There has appeared, over and over again, conflict between right and right.

(Continued on Page 412)

USE OF PRISONERS FOR DRUG TRIALS

(Continued from Page 411)

From our posts of vantage we have watched the entrances and the exits of the characters and the unfolding of the plot of this drama, we have constantly asked ourselves one question· "Who if anyone, is the villain in the Play?"

From time to time we have made tentative judgments as indicated earlier in this report, but our final judgment indicates that our search has been successful and that the greatest villain has been identified. At times, he brazenly occupied the spotlight; at others he has been seen flitting in the shadows. More often his presence has been felt even while he remained hidden in the wings. That villain is human nature. The same character is also the knight in shining armour, the hero of the play.

COMMITTEE MEMBERS

Tinsley R. Harrison, M. D.
Chairman

J. N. Clanton, M. D.

Peter N. B. Peacock, M. D.

Byron B. Williams, Ph. D.

Reginald T. Hamner, L. LB.
Legal Counsel

L. P. Patterson
Secretary

Blood And Its Mysteries

More than 2,500 physicians, technologists and administrators are expected to attend the 23rd annual meeting of the American Association of Blood Banks, where Dr. Denton A. Cooley, the surgeon who has per formed more heart transplant operations than any other, will be the keynoter.

To be held in Houston November 16-20, this is the first AABB convention convening in Texas since the organization was formed in Dallas in 1947. Dr. Frank C. Coleman, Tampa, Florida, is President, and Dr. Enold H. Dahlquist, Jr., Providence, Rhode Island, President-elect of the Association.

The scientific program will include papers on advances in the use of platelets, frozen blood, the discovery of new blood sub-types, use of adenine in blood preservation and a symposium on antigen-antibody reactions. Dr. Nevin C. Hughes-Jones of St. Mary's Hospital Medical School, London, will be a participant.

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

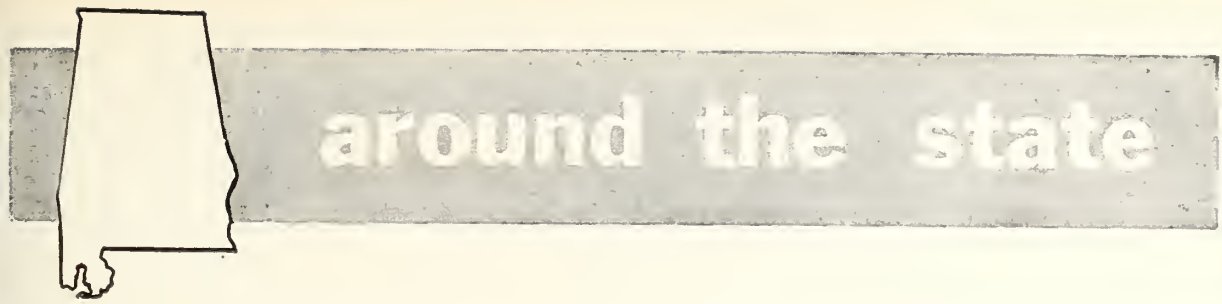
Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: MRS. ELIZABETH HARKINS, ACSW, *Coordinator of Admissions* or

CHARLES W. NEVILLE, JR., M. D., *Assistant Professor of Psychiatry and Medical Director*

Area Code 704 - 254-3201



Vital Statistics

NEW MEMBERS

Jefferson County

Lohmann, Herman Josef, b 29, mc University of Munster, West Germany, 1957, sb 68, 701 Princeton Avenue, S. W., Birmingham, Alabama, 35211. Path.

Madison County

Brown, John Augustus, Jr., b 31, mc Mississippi 60, recip. Miss. 69, Medical Arts Building, Huntsville, 35801. D.

Burlison, Pat Ed, b 35, mc University of Tennessee 60, recip. Tenn. 69, 930 Franklin Street, Huntsville, 35801. PL.

Ennis, John Matthews, b 36, mc Alabama 61, sb 62, 401 Lowell Drive, Huntsville, Alabama, 35801. D.

DEATHS

Butler County

Kendrick, James Erasmus, Greenville, Alabama—Deceased August 14, 1969.

Jefferson County

Bishop, Brooks, Birmingham, Alabama—Deceased July 13, 1969.

Cermak, Emil Charles, Birmingham, Alabama —Deceased July 23, 1969.

Payne, Edmund C., Birmingham, Alabama—Deceased July 25, 1969.

Sims, Thomas, Fairfield, Alabama—Deceased

NON-MEMBERS DEATHS

Coffee County

Russell, James Albert, New Brockton, Alabama—Deceased August 12, 1969.

NON-MEMBERS TRANSFERRED

Russell County

Barraza, Lionel G., moved from Phenix City to Louisiana.

CHANGE OF ADDRESS OF MEMBERS

Blount County

Murphree, Roland Erskine, Present Oneonta, to 915 South Broad Street, Scottsboro, Alabama, 35768.

Dallas County

Angle, David Lee, present Selma to 313 Sherwood Drive, Selma, Alabama 36701.

Moore, Jasper Duncan, present Selma, to P. O. Box 1345, Selma, Alabama, 36701.

Ross, Carlos James, present Selma, to P. O. Box 557, Selma, Alabama, 36701.

Franklin County

Anderson, James Burns, Jr., present Russellville, to 318 Coffee Avenue, N. E., Russellville, Alabama, 35653.

Houston County

Coe, Howell Dean, Jr., present Dothan, to 1520 East Main Street, Dothan, Alabama, 36301.

Jefferson County

Caveny, Elmer Leonard, present Birmingham, to 3516 Robin Drive, Birmingham, Alabama, 35223.

Ryan, Robert T., Jr., present Fairfield, to 800 Montclair Road, Birmingham, Alabama, 35213.

Toner, Stephen John, present Birmingham,

to 1919 7th Avenue, South, Birmingham, Alabama, 35233.

Upchurch, James C., present Birmingham, to 320 Tuscaloosa Avenue, Birmingham, Alabama, 35211.

Vaughn, Henry M., present Birmingham, to 3808 Spring Valley Circle, Mountain Brook, Birmingham, Alabama, 35223.

Mobile County

Daniels, Charles William, present Mobile, to 156 Louiselle Street, Mobile, Alabama, 36607.

Montgomery County

Collins, Dierdre S., present Montgomery, to Box 44130, Panorama City, California, 91412.

Garrick, Jean, present Montgomery, to 2119 East South Boulevard, Montgomery, Alabama, 36111.

Morgan County

Phillips, Edwin J., present Decatur, to 1201 Somerville Road, Decatur, Alabama, 35601.

Tuscaloosa County

Turpin, Delilah L., present Tuscaloosa, to 813 Daniel Drive, Clemson, South Carolina, 37631.

Walker County

Ivey, William H., present Jasper, to 303 Wildwood Drive, Jasper, Alabama, 35501.

CHANGE OF SPECIALTIES

Jefferson County

Campbell, Ernest Sheppard, 1909 Laurel Road, Vestavia Hills, Birmingham, Alabama. Surgeon.

Douglas, Gilbert Franklin, Jr., 2009 Kentucky Avenue, Vestavia Hills, Birmingham, Alabama. Internal Medicine.

Ryan, Robert Thomas, Jr., 800 Montclair Road, Birmingham, Alabama. Radiology.

NEW COUNTY SOCIETY OFFICERS

Russell County

Blake, T. B., Jr. — President

Cohen, M. D. — Vice-President

Chi, David T. W. — Secretary

Webber, J. M. — Treasurer

Censors: Mitchell, J. S., Chairman
Knowles, C. M., Jr.
Mims, W. B.
Warr, W. S.

NEW TELEPHONE NUMBERS

Abele, H. B., Birmingham	592-8976
Accinno, M. A., Birmingham	879-6346
Alford, C. A., Jr., Birmingham	934-4462
Allarde, R. R., Birmingham	934-4749
Allen, G. E., Jr., Leeds	699-2091
Allen, T. H., Birmingham	934-4675
Armour, W. S., Birmingham	967-2111
Arnold, S. W., Birmingham	251-3081
Bagby, H. C., Birmingham	822-9141
Bancroft, J. D., Birmingham	823-1033
Bargeron, L. M., Jr., Birmingham	934-4483
Barnett, R. V., Birmingham	933-0447
Baugh, A. T., Jr., Birmingham	324-1509
Baxley, W. A., Birmingham	934-4157
Bean, S. K., Birmingham	674-6462
Bearman, A. J., Birmingham	836-3211
Becton, J. A., Birmingham	592-8976
Benton, J. W., Jr., Birmingham	934-4974
Blankenship, B. E., Birmingham	252-0140
Bleidt, L. C., Birmingham	933-4433
Boname, J. R., Birmingham	592-7532
Bradley, J. D., Jr., Birmingham	324-6581
Brannon, R. M., Birmingham	879-4771
Branscomb, B. V., Birmingham	934-4731
Brascho, D. J., Birmingham	934-4652
Brice, D. W., Birmingham	934-4011
Briggs, D. D., Jr., Birmingham	252-6121
Brown, H. D., Birmingham	328-2594
Butterworth, C. E., Jr., Birmingham	934-4710
Caceres, J. A., Fairfield	428-6271
Campbell, E. S., Jr., Birmingham	823-1033
Capra, C. S., Birmingham	934-4011
Carey, J. H., Birmingham	934-4636

(Continued on Page 416)



Blue Shield's new URC program is designed to minimize your collection problems through payments based on physicians' usual, reasonable and customary fees.

BLUE CROSS-BLUE SHIELD OF ALABAMA



(Continued from Page 414)

Carmichael, D. E., Birmingham 934-4379
Carmichael, J. D., Birmingham 252-9906
Carter, R. W., Birmingham 322-3359
Casey, A. E., Birmingham 323-6135
Cassady, G. E., Birmingham 934-4680
Casten, G. G., Birmingham 934-5274
Caveny, E. L., Birmingham 934-4632
Ceballos, Ricardo, Birmingham 934-4384
Cezayirli, Cemil, Birmingham 592-8976
Chenault, S. B., Decatur 355-6222
Cheraskin, Emanuel, Birmingham 934-4721
Clark, E. C., Birmingham 324-6581
Cline, W. M., Birmingham 328-4522
Cloyd, W. L., Birmingham 252-6121
Cole, G. W., Birmingham 934-4713
Collins, C. D., Birmingham 324-6581
Collins, H. G., Birmingham 251-4231
Comer, J. F., Birmingham 933-0491
Compton, M. E., Jr., Birmingham 251-8167
Conwell, H. E., Birmingham 933-0491
Corssen, Guenter, Birmingham 934-4696
Coston, R. M., Birmingham 871-5050
Crabtree, J. C., Jr., Birmingham 785-2511
Crowe, A. D., Birmingham 328-0845
Cunningham, R. D., Birmingham 934-4280
Dabbs, J. M., Birmingham 787-1457
Daniel, W. A., Jr., Birmingham 934-4011
Davie, J. C., Birmingham 328-8770
Davis, J. E., Leeds 699-2091
Davis, Sarah F., Birmingham 934-4461
Davis, T. M., Jr., Bessemer 425-4395
Deason, A. M., Jr., Birmingham 328-0845
Del Vecchio, P. A., Woodward 428-1241
Denny, R. C., Jr., Irondale 592-3746
Diethelm, A. G., Birmingham 934-5200
Dillon, H. C., Birmingham 934-4280
Dimick, A. R., Birmingham 934-4903
Dixon, Gloria A., Birmingham 836-8488
Dixon, J. M., Birmingham 324-3305
Dodge, H. T., Birmingham 934-4609
Dodson, W. H., Birmingham 322-3391
Donald, J. M., Birmingham 328-0122
Doss, Faye W., Birmingham 251-9272
Douglas, G. F., Birmingham 933-1540
Dowdy, E. G., Birmingham 934-4696
Dowling, E. A., Birmingham 934-4978
Eddleman, E. E., Jr., Birmingham 324-6581
Edwards, E. H., Jr., Leeds 699-2091
Edwards, W. S., III, Birmingham 934-4634
Elliott, Claire B., Birmingham 323-6135
Elmore, J. D., Birmingham 328-2054
Erdemir, H. A., Birmingham 934-4696
Estock, Robert, Birmingham 934-4912
Fargason, C. C., Jr., Birmingham 251-0256
Farmer, T. A., Jr., Birmingham 934-4964
Finley, Sara, Birmingham 934-4968
Finley, W. H., Birmingham 934-4968
Finney, J. O., Birmingham 934-5187
Fisher, C. J., Birmingham 251-0256
Fleming, W. C., Birmingham 934-4131
Foster, G. L., Birmingham 934-4869
Frommeyer, W. B., Jr., Birmingham 934-4326
Fulton, W. F., IV, Birmingham 822-3391
Galbraith, J. G., Birmingham 934-4655
Garrett, J. M., Birmingham 324-6581
Gibbs, S. R., Bessemer 785-2121
Glover, L. B., Birmingham 934-4011
Goldfarb, Morton, Birmingham 871-5283
Goldstein, Ben, Birmingham 252-4606
Gray, G. W., Birmingham 328-6337
Grimes, B. M., Birmingham 252-6121
Guffin, G. T., Birmingham 631-4871
Haden, H. H., Jr., Birmingham 933-0760
Halsey, J. H., Jr., Birmingham 934-4238
Hammack, W. J., Birmingham 324-6581
Harper, Ann L., Birmingham 324-9571
Harris, S. E., Birmingham 324-3651
Harrison, T. R., Birmingham 871-4383
Harsh, J. F., Birmingham 323-2743
Hathaway, B. M., Birmingham 324-6581
Hays, J. H., Birmingham 322-4237
Hazelrig, C. G., Birmingham 324-6581
Hefner, L. L., Birmingham 934-4651
Henderson, R. E., Birmingham 328-6337
Henley, F. T., Birmingham 592-0081
Herlihy, C. E., Birmingham 328-2031
Hicks, G. M., Birmingham 934-5131
Hill, S. R., Jr., Birmingham 934-4533
Hirschowitz, B. I., Birmingham 934-4618
Hofammann, K. E., Jr., Birmingham 933-0290
Holdefer, W. F., Birmingham 934-4806
Holley, H. L., Birmingham 934-4304
Holt, J. H., Jr., Birmingham 324-6581
Ingle, L. R., Jr., Bessemer 428-6378
Irwin, W. H., Leeds 699-2091
James, T. N., Birmingham 934-4236
Johnson, B. K., Birmingham 251-9106
Johnson, I. M., Birmingham 324-6581

Johnson, J. C., Birmingham 823-1033
Jones, W. B., Birmingham 934-4791
Karl, E. A., Birmingham 324-6567
Kent, S. P., Birmingham 934-4481
Kirklin, J. W., Birmingham 934-5167
Klapper, M. S., Birmingham 934-4626
Landers, B. L., Jr., Birmingham 328-3294
LeMay, B. P., Birmingham 328-8996
Levine, M. A., Birmingham 251-4141
Levy, D. S., Adamsville 674-6462
Lightfoot, P. M., Jr., Montgomery 269-1486
Little, S. C., Birmingham 934-4871
Litzinger, M. J., Jr., Birmingham 251-6997
Longino, L. A., Birmingham 323-8901
Lupton, C. H., Jr., Birmingham 934-2419
Magruder, T. V., Jr., Birmingham 251-8265
Martin, W. B., Birmingham 879-8839
Mathis, J. W., Graysville 674-9422
McAuley, M. D., Jr., Birmingham 934-4011
McCallum, C. A., Jr., Birmingham 934-4509
McCaslin, D. L., Birmingham 592-0081
McCraw, E. F., Birmingham 934-4772
McDowell, H. A., Jr., Birmingham 934-4742
McGowan, E. I., Birmingham 934-5384
McLallen, C. D., Jr., Birmingham 328-8173
McVicker, F. A., Birmingham 328-0171
Meador, C. K., Birmingham 934-4533
Merck, D. E., Birmingham 251-6997
Miller, R. E., Birmingham 934-4385
Miree, M. F., Birmingham 328-1125
Montgomery, H. T., Montgomery 288-7411
Moody, F. G., Birmingham 934-5147
Moody, W. E., Moulton 592-0384
Moore, E. L., Birmingham 879-3944
Morgan, P. A., Jr., Birmingham 322-3359
Morris, A. W., Birmingham 934-4384
Mowry, R. W., Birmingham 934-4429
Nicholson, W. H., Jr., Birmingham 254-3036
Norman, J. R., Birmingham 934-4180
Noto, T. A., Birmingham 934-4713
Nuckols, F. J., Birmingham 592-8976
Nunis, J. B., Birmingham 252-6121
Ott, W. R., Birmingham 836-6284
Owens, A. H., Jr., Birmingham 328-9830
Palmer, S. D., Birmingham 822-8571
Pappas, D. G., Birmingham 251-7169
Pardue, W. O., Jr., Birmingham 785-2121
Patton, F. M., Birmingham 592-0081
Peacock, P. N. B., Birmingham 934-4993
Pearson, R. S., Birmingham 787-1411
Phillips, R. D., Fairfield 783-2164
Pittman, Constance S., Birmingham 934-4484
Pitts, W. R., Pleasant Grove 428-1241
Polt, Sarah S., Birmingham 324-6581
Preston, R. T., Jr., Fairfield 787-2361
Ragsdale, M. C., III, Birmingham 328-0582
Randall, F. M., Birmingham 933-0491
Reeves, T. J., Birmingham 934-4651
Ricketts, G. L., Jr., Birmingham 251-4287
Riheldaffer, W. H., Birmingham 324-9571
Rike, H. C., Birmingham 785-7626
Ritchey, H. M., Birmingham 592-8976
Robinson, Leonard, Birmingham 934-4978
Ronderos, A. D., Birmingham 252-6121
Rosser, R. G., Birmingham 251-9274
Roth, R. E., Birmingham 934-4688
Rountree, W. B., Birmingham 798-7868
Rowe, L. C., Birmingham 933-0348
Russell, J. W., Birmingham 252-9931
Russell, R. O., Jr., Birmingham 934-4791
Russell, R. T., Birmingham 322-2741
Salter, M. M., Birmingham 934-4652
Samuels, J. W., Jr., Birmingham 324-3950
Sanders, B. B., Birmingham 787-1457
Scofield, G. F., Birmingham 252-6121
Scott, E. M., Jr., Birmingham 933-0637
Scott, E. V., Birmingham 328-0453
Seibold, J. L., Birmingham 871-7184
Shaw, June F., Birmingham 934-4691
Sheffield, L. T., Jr., Birmingham 934-4821
Shepard, R. B., Birmingham 934-4673
Sherlock, E. C., Birmingham 934-4675
Shirley, S. W., Birmingham 934-4933
Silberman, D. J., Birmingham 592-8976
Simon, H. E., Birmingham 871-1457
Simpson, J. W., Birmingham 934-4137
Slappey, W. J., Birmingham 879-6034
Smith, G. H., Jr., Birmingham 933-1171
Smith, P. H., Birmingham 833-7113
Smith, T. L., Jr., Birmingham 252-9931
Sox, J. H., Birmingham 822-1319
Spruell, W. H., Birmingham 252-6121
Stephens, A. B., Jr., Birmingham 328-2055
Straumfjord, J. V., Jr., Birmingham 934-4713
Strong, J. B., Jr., Birmingham 322-0453
Sussex, J. N., Birmingham 934-4634
Taylor, W. H., Jr., Birmingham 252-6121
Teague, E. B., Birmingham 322-3359

(Continued Next Page)

Thrasher, Helen R., Birmingham	833-7638	Ward, J. L., Birmingham	322-0453
Tidwell, O. K., Birmingham	251-4287	Watson, H. E., Birmingham	251-8167
Timberlake, Landon, Birmingham	328-0845	Wells, B. B., Birmingham	324-6581
Toner, S. J., Birmingham	934-4011	White, J. E., Birmingham	833-3476
Tucker, M. S., Birmingham	425-2341	Whitehurst, W. R., Birmingham	322-7418
Turman, A. E., Birmingham	934-4933	Whitman, Marcus, Birmingham	933-0491
Turner, G. P., Jr., Birmingham	251-3246	Wilson, J. D., Birmingham	871-6026
Tyler, R. E., Birmingham	933-1128	Wilson, T. A. S., Birmingham	324-2461
Underwood, J. W., Birmingham	322-3359	Windsor, J. L., Bessemer	425-1171
Upchurch, J. C., Birmingham	254-3963	Woodall, P. S., Birmingham	933-0447
Vaughn, H. M., Birmingham	322-3359	Woodard, J. R., Birmingham	934-5313
Walker, J. H., Birmingham	933-0460	Woodfin, M. C., Jr., Montgomery	265-8502
Walton, R. A., Birmingham	252-0457	Yelton, C. L., Birmingham	934-4667
Ward, J. K., Birmingham	592-8976	Young, L. S., Bessemer	425-3261

U. Of A. Medical Center Gets Arthritis Research Grant

In the Medical College of the University of Alabama, Birmingham, and in 20 other special centers across the nation, physicians are treating arthritis patients and researchers are probing into the depths of the mysteries of Arthritis.



H. L. Holley, M. D.

Known as Arthritis Clinical Research Centers, these 21 are funded by special grants from the Arthritis Foundation. And the program director for Alabama is Howard L. Holley, M. D., Professor of Medicine, and Director of the Rheumatology Division.

Alabama's share in the current funding is $20,000, over a period extending from last July 1 to June 30, 1970.

Other schools in the South participating in these funds are two in Georgia, Emory's School of Medicine, Atlanta, and the Medical College of Georgia, Talmadge Memorial Hospital, Augusta; one in Tennessee, the University's College of Medicine, Memphis; to which might be added Southwestern Medical School, University of Texas, Dallas; and possibly Johns Hopkins School of Medicine, Baltimore, and St. Louis University School of Medicine.

Purposes of the centers are listed as threefold:

—To provide the most expert treatment possible for men, women and children suffering from arthritis.

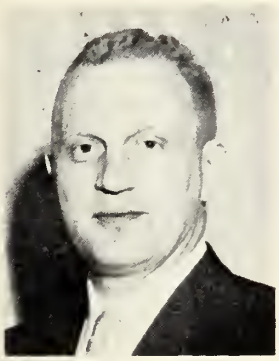
—To teach physicians, medical students and allied health professionals about the disease and how best to treat arthritis patients.

—To investigate the many facets of arthritis, its causes, its progression, and ways and means for improving therapy.

Three of the participating Centers were added with the current announcement, bringing the total number from 18 to 21. Those added are Yale University School of Medicine, the University of Michigan Medical School, and the University of Cincinnati College of Medicine.

Alabamian Chosen Vice President Of ABOFP

An Alabama Doctor has been elected vice President of the newly formed American Board of Family Practice; a Californian was elected President and a Kentuckian Secretary-Treasurer at the same meeting, held in New York in July.



Dr. Michaelson

The Alabamian is Dr. Julius Michaelson of Foley, the Californian Dr. John G. Walsh of Sacramento, and the Kentuckian Dr. Nicholas J. Pisacano of Lexington. The board also appointed an Examination Committee, a Credentials Committee, and representatives to the proposed AMA Residency Review Committee for Family Practice.

Dr. Michaelson is a native of Bessemer, was elected National Secretary of Hi Y Clubs and also was elected to the National Honor Society during his high school days; was President of the Freshman and Sophomore Classes successively during his undergraduate days at L. S. U. He made his varsity letter in football and, in Medical School at L. S. U. was on the Student Council and on the Editorial Board of the Journal.

Currently Treasurer of the American Academy of General Practice, Dr. Michaelson is a past President of the Alabama chapter, AAGP; a past President of the Baldwin County Medical Society, is a Counsellor from the 2nd Congressional District of MASA; in civic affairs has served as Chairman, Foley School Board of Trustees, is a past President of the Optimist Club, and his hobby is "ham radio," operating K4TWB.

Dr. Michaelson is married to the former Marilyn McDaniel of Nashville, Tennessee.

His eldest son, Jeffry, is with a tire company in New Bedford, Massachussets. His second son, Frederick, is a senior this year at L. S. U. And the youngest, Julius, Jr., (known to his intimates as Jay), a sophomore this year at L. S. U., is following in the football footsteps of his father, and will be on the University's varsity team. The two older sons are married, but have no children.

A Doctor's Notebook From Yesterday

Notebooks of famed Dr. George W. Ketchum of Mobile (about whom the Journal has carried a full length feature) are fascinating memorabilia in the possession of Dr. M. Vaun Adams of Mobile, member of AMA's House of Delegates. Pocket-size, black leather-bound, these books contain a wealth of interesting glimpses into the past, generally a terse record of Dr. Ketchum's day-to-day professional services.

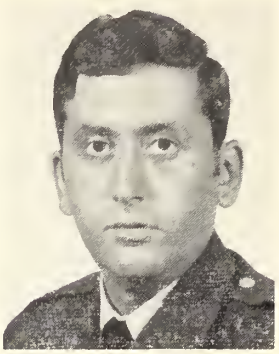
A random volume is one dated 1892, wherein the roll-call of patients reads like a roster of Who's Who in Mobile, such names as:

Barrett and Brewer, Agee and Abbott, Casey and Carney, Dumas, Burgess, and Lyons, Weber, Webb, Wade and Ward, Sossaman, Turner, Taylor and Vaughn, Pincus and Eichold, Rhett, Tilden and Dukes, Metzger, Hubbard, Christian and Frost, Ogden, Robinson, Hamilton, Sibley and Oliphant, Dunlap, Huger and Hartwell, Wilmer, Stone and Quill, Broun, Brown, Browne, Jones and Smith, and a whole host more.

In the back of each little volume are pages for "Obstetric Engagements" and they are well filled. One page contains the names and addresses, the page opposite carrying notations of Time of Expected Confinement, Date of Attendance, and Remarks.

The entries are in a precise, clear and completely legible handwriting, quite different from that generally accredited to the medical profession.

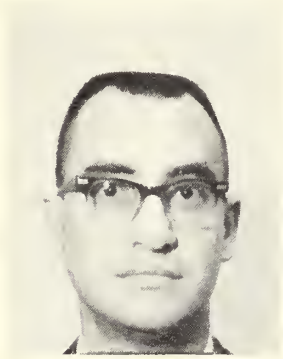
New Physicians Licensed To Practice In Alabama



Sanford Victor Berens, M. D., Dalhousie University School of Medicine, Nova Scotia, 1965, Reciprocity with National Board of Medical Examiners—Intends to locate in Huntsville.



Bolling Jones Feild, M. D., Medical College of Virginia, 1966, Reciprocity with Virginia—Intends to locate in Birmingham.



Marshall Campbell Dunaway, M. D., Emory University School of Medicine, 1964, Reciprocity with Georgia—Intends to locate in Montgomery.



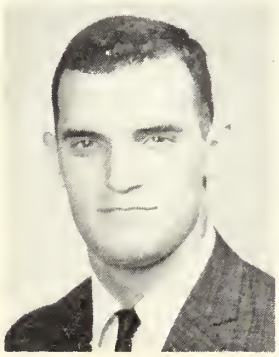
Joseph Angelo Ferlisi, M. D., State University of New York at Buffalo School of Medicine, 1959, Reciprocity with National Board of Medical Examiners—Intends to locate in Enterprise.



Donald Benjamin Doty, M. D., Stanford University School of Medicine, 1962, Reciprocity with the National Board of Medical Examiners—Intends to locate in Birmingham.



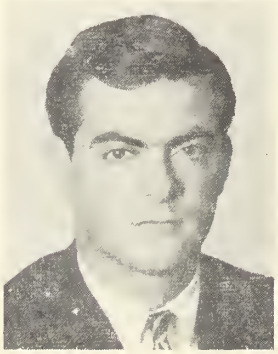
Frederick John Fricke, Jr., M. D., Baylor University School of Medicine, 1968, Reciprocity with Texas—Intends to locate in Birmingham.



William King Dunham, Jr., M. D., Medical College of Alabama, 1968, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Frank Monroe Griffin, Jr., M. D., Medical College of South Carolina, 1966, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Richard Henry Esham, M. D., University of Louisville School of Medicine, 1967, Reciprocity with Kentucky—Intends to locate in Birmingham.



John Gordon Hankins, M. D., Tulane University School of Medicine, 1964, Reciprocity with Louisiana—Intends to locate in Birmingham.



James Elroy Huddlestun, M. D., Indiana University School of Medicine, 1963, Reciprocity with Indiana—Intends to locate in Florala.



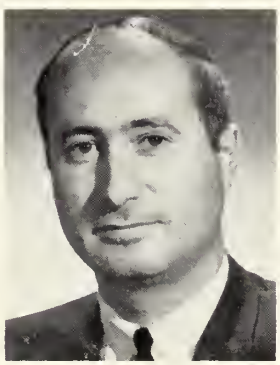
Gene Deloin Ratcliff, M. D., Tulane University School of Medicine, 1965. Reciprocity with Louisiana—Intends to locate in Mobile.



Richard Norton Lamb, M. D., Harvard Medical School, 1961, Reciprocity with the National Board of Medical Examiners—Intends to locate in Birmingham.



Millard Mason Roberts, M. D., University of Miami School of Medicine, 1966, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Irwin Lewis, M. D., McGill University, 1958, Reciprocity with the National Board of Medical Examiners—Intends to locate in Birmingham.



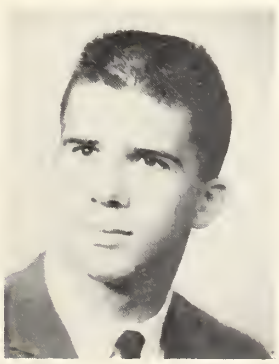
Alex David Russakoff, M. D., Tufts University School of Medicine, 1962. Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Joel Lawrence Martin, M. D., State University of New York Downstate Medical Center, 1964, Reciprocity with National Board of Medical Examiners—Intends to locate in Montgomery.



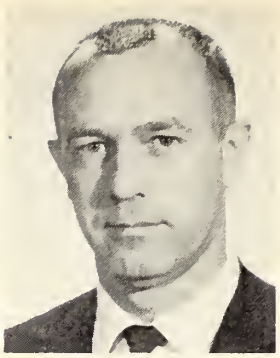
Anthony Pasquale Scapicchio, M. D., New Jersey College of Medicine, 1963, Reciprocity with National Board of Medical Examiners—Intends to locate in Florala.



Robert Gary Martin, M. D., University of Louisville School of Medcine, 1967, Reciprocity with Kentucky—Intends to locate in Birmingham.



M. Barry Siegel, M. D., University of Cincinnati College of Medicine, 1966. Reciprocity with Ohio—Intends to locate in Southeastern Alabama.



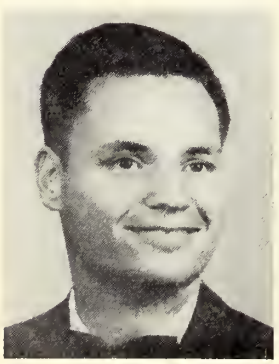
Samuel Landis Stover, M. D., Jefferson Medical College, 1959, Reciprocity with Pennsylvania—Intends to locate in Helena.



James Chanslor Thoroughman, M. D., Emory University School of Medicine, 1927, Reciprocity with Georgia—Intends to locate in Opelika.

Everett Gaines Veach, M. D., Emory University School of Medicine, 1962, Reciprocity with Georgia—Intends to locate in Opelika.

Picture not available



Charles Huey Wingo, M. D., University of Tennessee School of Medicine, 1967, Reciprocity with Tennessee—Intends to locate in Birmingham.

INDEX TO ADVERTISERS

Arch Laboratories ... 312

Blue Cross-Blue Shield ... 415
The Bradley Center ... 380
Breon Laboratories ... 387, 388, 389, 390
Bristol Laboratories ... 366
Burroughs-Wellcome ... 375

Campbell Soup Company ... 363
Classified ... 350, 352

Geigy Pharmaceuticals ... 342, 343, 368, 369, 405, 406, 407
Glenbrook Laboratories ... 321
Guest House Motel ... 323

Highland Hospital ... 412
Hynson, Westcott & Dunning ... 309

Lederle Laboratories ... 311, 322, 335, 351
Eli Lilly & Company ... 1st Cover, 354

Merck Sharp & Dohme ... 346, 347, 348
Wm. S. Merrell Company ... 373

National Drug Company ... 2nd Cover, 399, 400

Parke Davis & Company ... 316
Pfizer Laboratories ... 328, 329
Wm. P. Poythress & Co. Inc. ... 378

Riker Laboratories ... 334, 335, 394, 395
A. H. Robins ... 340
Roche Laboratories ... 314, 315, 376, 377, 4th Cover

Sandoz Pharmaceuticals ... 313
G. D. Searle ... 364, 365
Smith, Kline & French Labs. ... 319, 385
Strasenburgh Laboratories ... 325
The Stuart Company ... 353

Warner Chilcott ... 337, 338, 409, 410
Wyeth Laboratories ... 326, 327, 382, 383, 3rd Cover

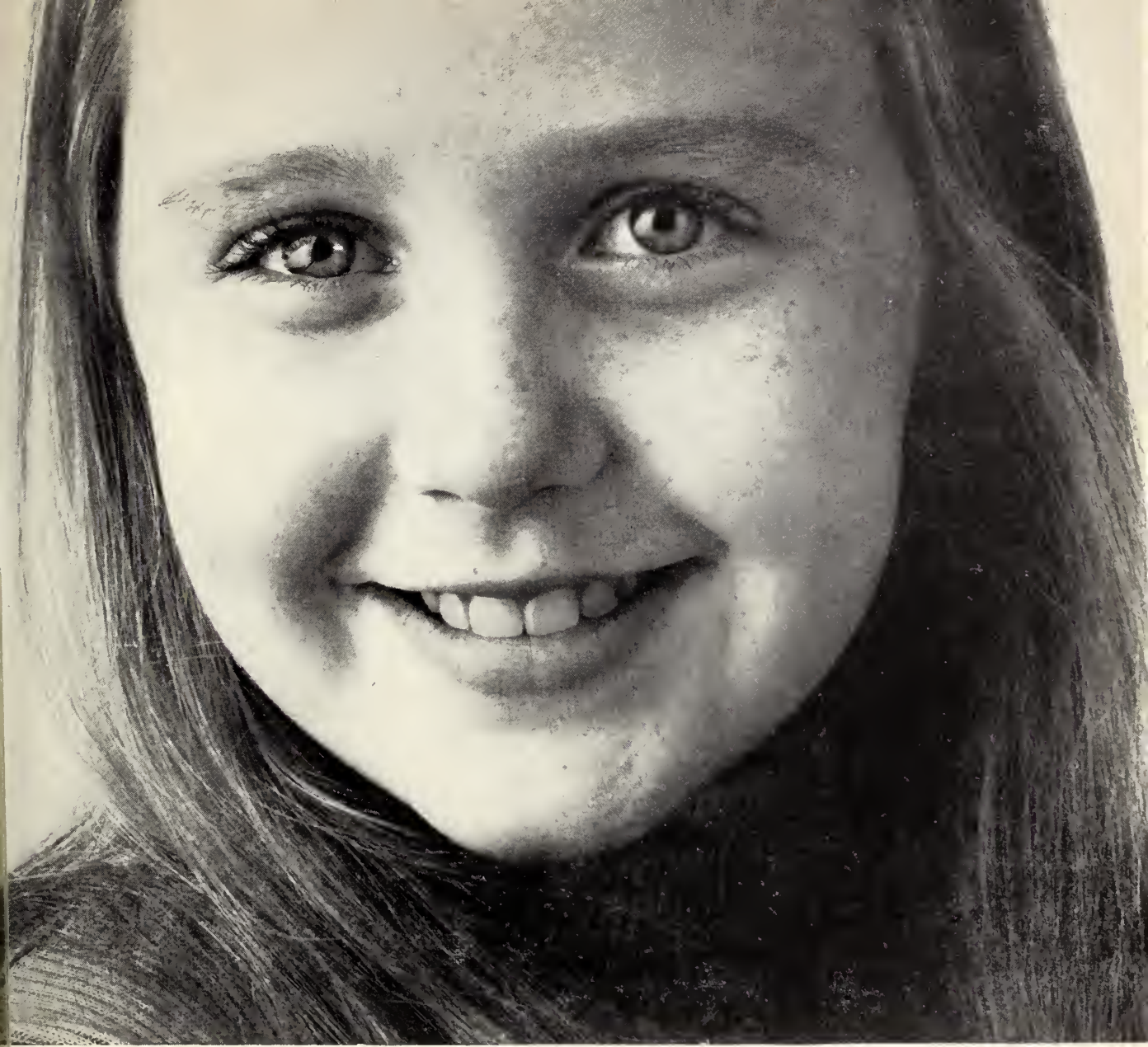


Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**

(potassium phenoxymethyl penicillin) Wyeth®

Exchange Office
Francis A. Countway Lib. of
Medicine
10 Shattuck St.
Boston, Massachusetts 02115



When disease is ruled out and psychic tension is implicated

Valium® (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcitec states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

JOURNAL
of the Medical Association of the State of ALABAMA

THE STATE OF ALABAMA 1873
DISPLAY SHELVES

IN THIS ISSUE

Physiological and Psychological Evaluation of the Estrogen Deprived Patient 459

The Latest Concepts in Surgical Management of Peptic Ulcer Disease 464

Medico-Legal Aspects of Human Experimentation and Transplantation . . . 489

THE FRANCIS A. COUNTWAY LIBRARY OF MEDICINE BOSTON
28 NOV 1969

Write it any way you please

Cordran®
Flurandrenolone



Cream Cordran contains flurandrenolone, 0.05 percent, stearic acid, cetyl alcohol, mineral oil, polyoxyl 40 stearate, ethylparaben, glycerin, and purified water.

Lilly

Additional information available upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

900415

Medicine
10 Shattuck St.
Boston, Mass.

NOVEMBER 1969



Dear Doctor, You made me what I am today— a whole lot slimmer!

TEPANIL—the right start in support of th weight-control program *you* recommend. reduces the appetite. Doesn't kill it. Weig loss is significant—gradual—yet there is relatively low incidence of CNS stimul tion. Because TEPANIL works on th appetite, not on the "nerves."

Contraindications: Cancurrently with MAO inhibitors, in patie hypersensitive to this drug; in emotionolly unstoble patie susceptible ta drug abuse.

Warning: Although generally safer than the amphetamin use with great cautian in patients with severe hypertensian severe cardiovascular diseose. Do not use during first trimester pregnancy unless potential benefits outweigh potentiol risks.

Adverse Reactions: Rarely severe enough to require discontinuotion of th apy, unpleasant symptoms with diethylpropion hydrochloride have been repor to occur in relatively law incidence.

As is characteristic of sympathomimetic agents, it may accasianally cause CNS effects such insamnio, nervausness, dizziness, anxiety, and jitteriness. In contrast, CNS depressian has b reported. In a few epileptics an increase in canvulsive episades has been reported.

Sympathomimetic *cardiovascular effects* reparted include anes such as tachycardia, precor poin, arrhythmia, palpitation, and increased blaad pressure. One published repart descri T-wove changes in the ECG af o healthy yaung male after ingestion af diethylprapian hy chloride; this was an isalated experience, which has nat been reparted by athers.

Allergic phenamena reported include such canditians as rash, urticaria, ecchymosis, and erythe

Gastraintestinal effects such as diarrhea, canstipatian, nausea, vamiting, and obdominal dis fort have been reported.

Specific reports on the hematopoietic system include twa each of bone marrow depres agronulocytosis, and leukopenio.

A voriety of miscellaneous adverse reactians have been reparted by physicians. These inc complaints such as dry mauth, headache, dyspnea, menstrual upset, hair lass, muscle decreased libido, dysuria, and palyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallo whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour b meals. If desired, an additianal tablet may be given in midevening to overcame night hun Use in children under 12 years af age is nat recammended.

Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride)

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144 T-918A U.S. PATENT NO. 3,001,910 5/

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON

28 NOV 1969

LACTINEX®

TABLETS & GRANULES

■ **to help restore and stabilize the intestinal flora**

■ **for fever blisters and canker sores of herpetic origin**

Lactinex contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.[1,2,3,4,5,6,7,8]

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.

Baltimore, Maryland 21201

(LX-05)

References:
(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., 9-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, .: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., s., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

THE JOURNAL

of the

Medical Association of the State of Alabama

Volume 39 • November, 1969 • No. 5

Office of Publication
19 So. Jackson St. Montgomery, Ala. 36104
Subscription Price $5.00 Per Year
$1.00 Per Copy

Second Class Postage Paid at Montgomery, Alabama. Published monthly in Montgomery at 19 South Jackson Street.

Editor-in-Chief
William L. Smith, M. D. Montgomery

Managing Editor
L. P. Patterson Montgomery

Assistant Managing Editor
Mary Nell Williford Montgomery

Associate Editors
J. P. Collier, M. D. Tuscaloosa
John M. Chenault, M. D. Decatur
M. Vaun Adams, M. D. Mobile

Officers of the Association

President
C. Kermit Pitt, M. D. Decatur

President-Elect
S. Buford Word, M. D. Birmingham

Vice-Presidents
F. M. Phillippi, Jr., M. D. Brewton
J. E. Cameron, M. D. Alexander City
O. Emfinger, M. D. Union Springs
Wood S. Herren, M. D. Birmingham

Secretary-Treasurer
William L. Smith, M. D. Montgomery

Executive Director
L. P. Patterson Montgomery

The State Board of Censors
John M. Chenault, M. D., Chmn. Decatur
J. P. Collier, M. D. Tuscaloosa
Hugh E. Gray, M. D. Anniston
Paul W. Burleson, M. D. Birmingham
L. L. Hill, M. D. Montgomery
M. Vaun Adams, M. D. Mobile
J. D. Bush, M. D. Gadsden
E. L. Strandell, M. D. Brewton
John W. Davis, Jr., M. D. Montgomery
J. Garber Galbraith, M. D. Birmingham

State Health Officer
Ira L. Myers, M. D. Montgomery

Delegates and Alternates to the American Medical Association

(Terms expiring December 31 of year shown.)

1970
Delegate—E. Bryce Robinson, Jr., M. D., Fairfield
Alternate—W. E. White Anniston

1971
Delegate—M. Vaun Adams, M. D. Mobile
Alternate—E. L. McCafferty, Jr., M. D. Mobile
Delegate—P. W. Burleson, M. D. Birmingham
Alternate—Robert Parker, M. D. Montgomery

CONTENTS

President's Page 426

The Woman's Auxiliary 432

Editorial Comment 434

- Is Organized Medicine Pursuing the Lemming's Course? 434
- What is Meaning of Spread In Gonorrheal Infection? 436
- It is Also A Month Significant To Medicine 437

Fathers and Sons In Medicine 438

- The Doctors Hughes Kennedy of Birmingham 438
- The Selden Harbour Stephens, Sr. and Jr. 441
- The Goldsteins of Montgomery 445

Rubella Vaccine Recommendations 448

The AMA Convention of 1869, Howard L. Holley, M. D., Birmingham 456

Scientific Section 459

- Physiological and Psychological Evaluation of the Estrogen Deprived Patient, O. Thomas Bolding, M. D., and Herman C. Wilcutt, Ph.D., Birmingham 459
- The Latest Concepts in Surgical Management of Peptic Ulcer Disease, Frank G. Moody, M. D., Birmingham 464

Around the State 473

- Vital Statistics 473
- Storm Veteran, MASA Ex-Prexy, In Next Year's 50-Year Club 478
- Paid With Tokens, Mental Patients Show Improvement 482

Hobbies to Fill A Doctor's Leisure 485

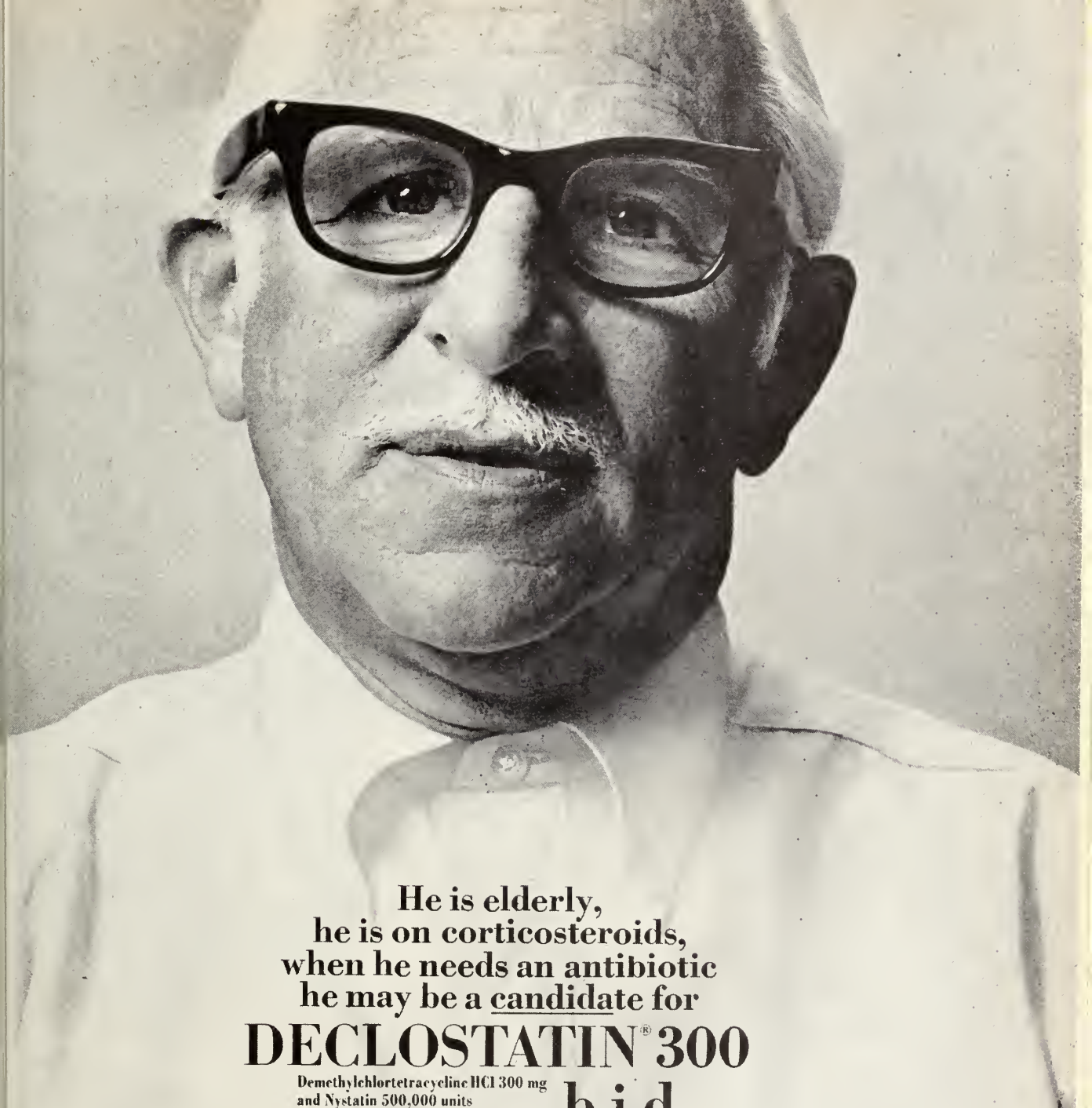
Legal Page: 489

- Medico-Legal Aspects of Human Experimentation and Transplantation 489

The Month in Washington 497

Alabama Department of Public Health 508
Pesticide Program Begun 508

Physician Placement Service in Alabama 514



He is elderly, he is on corticosteroids, when he needs an antibiotic he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

d susceptible patients against intestinal monilial over- during broad-spectrum therapy—the protection of n is combined with demethylchlortetracycline in)STATIN.

our susceptible candidates, prescribe DECLOSTATIN road-spectrum therapy that prevents monilial wth.

dication: History of hypersensitivity to demethylchlortetracy- ıystatin.

: In renal impairment, usual doses may lead to excessive accumu- d liver toxicity. Under such conditions, lower than usual doses ated, and, if therapy is prolonged, serum level determinations dvisable. A photodynamic reaction to natural or artificial sun- been observed. Small amounts of drug and short exposure may an exaggerated sunburn reaction which may range from ery- severe skin manifestations. In a smaller proportion, photo- reactions have been reported. Patients should avoid direct to sunlight and discontinue drug at the first evidence of skin rt. Necessary subsequent courses of treatment with tetracy- ıuld be carefully observed.

ns: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES, A Division of American Cyanamid Company
Pearl River, New York

President's Page



C. Kermit Pitt

Members of the Inter-specialty Council and the Legislative Committee of the Medical Association of the State of Alabama and several officers and interested members of the Association met at the Mid-town Holiday Inn in Montgomery on Sunday, September 28, 1969, for the purpose of reviewing the actions of the latest Alabama legislative session as they pertained to the health field. Some 40 eager individuals participated in the review and associated discussion. Several interesting facts were evident. Among them was that although some good blows for health care were struck, examples being the implied consent and the controversial air pollution laws, the health of the people of Alabama may suffer from the new meat law which places red meat inspection in the hands of Agriculture.

The Medical Association experienced success and defeat in its efforts to influence favorable legislation. Of the 19 bills opposed by the Association 16 were defeated and some 39 favored by us passed. This year's legislative process appeared even more confused than usual. There is no doubt that if more information could have been obtained and more consideration given, some of the bills which we favored we might not have favored and some of those we opposed might have received our blessing. Perhaps more importantly, we might have taken a position relative to some of the issues upon which we remained neutral.

Several members of our central office staff worked with great diligence on our behalf. All of us as physicians may well regret that we did not involve ourselves to a greater extent.

Another fact which emerged from the September 28 meeting was that in this legislature friends of organized medicine were surprisingly limited in number and the influence of the Medical Association correspondingly reduced.

Many individuals and organizations have a legitimate and sincere interest in health care and the physician and organized medicine have no monopoly on such interest, but it is undoubtedly true that the medical profession is more completely dedicated to the promotion of good health for our people than any other group. This fact, together with the ever increasing state and federal encroachment on our efforts to promote health care demands that each of us must become involved in the political arena. Escape this fate we cannot; nor should we seek to do so. We must be willing to give of our time and our means and we must see that responsible and effective people represent us in the next session of the Alabama legislature.



C. Kermit Pitt, M. D.

once-popular treatment for back pains
as to have the seventh son of a seventh son
and or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

r headache, a sovereign remedy was
wear a snakeskin round one's head.



A realistic approach to pain relief



'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

ach tablet contains:
odeine Phosphate gr. 1/2 (Warning—
ay be habit forming), Phenacetin gr. 2 1/2,
spirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise f pain relief

W. & Co.' narcotic products are
ass "B", and as such are available on oral
escription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

Roniacol® Timespan®
(nicotinyl alcohol tartrate)



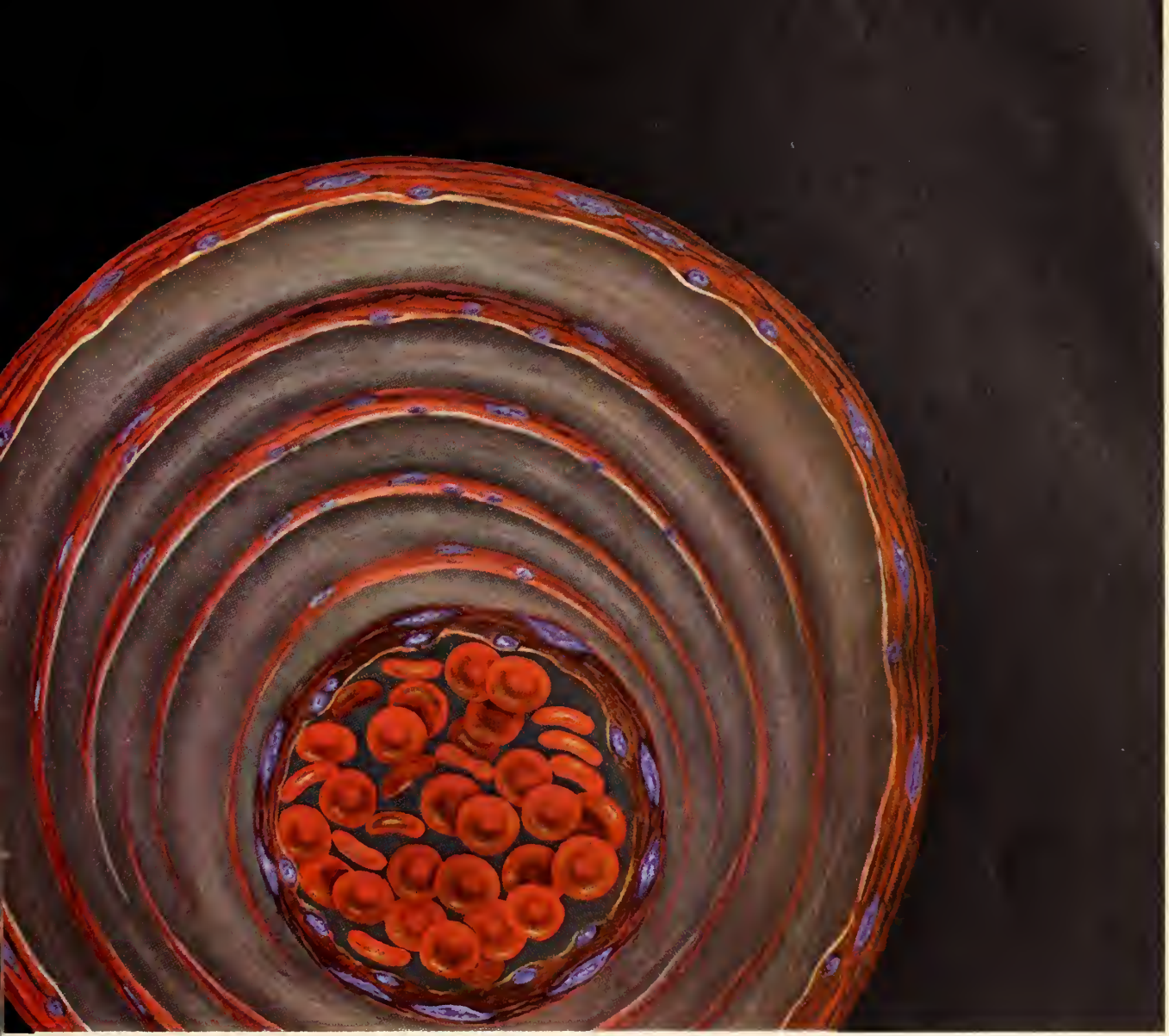
Because peripheral vasodilation is needed now... and must often be continued

Roniacol Timespan (nicotinyl alcohol tartrate) can make a significant contribution to effective treatment of peripheral vascular disorders. It is directed specifically toward improvement of peripheral blood flow, relief of ischemic symptoms, and the long-term management of these conditions.

Specific pharmacologic action—Roniacol (nicotinyl alcohol) acts selectively by relaxing smooth muscle of peripheral blood vessels. Onset of action is smooth and gradual, rarely causing severe flushing.

Relative freedom from side effects—Side effects that may occur occasionally with Roniacol seldom require discontinuation of therapy.

Prolonged, continuous drug release—Prolonged peripheral vasodilation is provided b sustained-release Roniacol Timespan (nicot alcohol tartrate) Tablets. Part of the drug be comes available immediately, the remainde continuously over a period of up to 12 hour and dilation of constricted peripheral vesse usually maintained. Thus, with a single dose medication, patients can enjoy the benefits increased peripheral blood flow in ischemic extremities for up to 12 hours.



ooth peripheral vasodilation from initial age...extended with ple, well-tolerated, b.i.d. dosage

onged action of Roniacol Timespan l alcohol tartrate) together with its nefits offer a therapeutically practical in the long-term management of al vascular disease–advantages y important for older patients.

rescribing, please consult complete nformation, a summary of which

ns: Conditions associated with circulation; e.g., peripheral vascular ascular spasm, varicose ulcers, ulcers, chilblains, Meniere's syn- id vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50 and 500.

ROCHE **Roche** LABORATORIES
Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Art is a conception of peripheral vasodilation.


Food 'n mouth disease

udin® phenmetrazine hydrochloride
udin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

traindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

ing: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.

Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.
Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000.
(B)R3-46-560-B

Under license from Boehringer Ingelheim G.m.b.H.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

For some, obesity can be a serious complication of moderate hypertension, diabetes, or pregnancy.

Preludin may be used to curb appetite in obesity associated with such conditions.

For use during pregnancy, please consult Warning paragraph. The use of Preludin in moderate hypertension should be accompanied by caution. In diabetes, the drug does not increase insulin requirements (requirements may be reduced as weight is lost).

One 75-mg. Endurets tablet taken between breakfast and midmorning will usually provide daylong and early-evening suppression of appetite.

Preludin® phenmetrazine hydrochloride Endurets® prolonged–action tablets

The Woman's Auxiliary

President, Mrs. Ben H. Johnson, Jr.
President-Elect, Mrs. Howard C. Johnson
Northeast District Vice President, Mrs. James D. Holliman, Jr.
Northwest District Vice President, Mrs. Gene Qualls
Southeast District Vice President, Mrs. George Andrews
Southwest District Vice President, Mrs. Andrew D. Henderson
WAMASA Editor, Mrs. William L. Smith

AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the Medical Association of the State of Alabama. I will support its activities, protect its reputation and ever sustain its high ideals."

The Fall Conference of State Presidents, Presidents-elect, National Officers and Chairmen held recently in Chicago at the fabulous Drake Hotel was a wonderful training experience. This was an opportunity to meet doctors' wives from every state and the problems we experience here in Alabama, we found are not ours alone. There is some comfort in this, but the important fact is, rather than pooling our ignorance we were advised and guided by competent National Chairmen and Officers. Mini Workshops were held by National Chairmen with participation by Regional Chairmen. We were given demonstrations of what we can do in the areas of Community Health, International Health, Home-Centered Health Care, Mental Health, and Safety-Disaster Preparedness. We brought back enough ideas and material to keep auxiliaries busy for the rest of the year. Of particular interest was the Package Program on Drug Abuse which is available for our use and we can develop programs to suit our local needs. Out of this will come ways to present this important material to our High School and Junior High students.



Mrs. Ben H. Johnson

Following this Conference was the Southern Regional Workshop in Dallas for Presidents-elect, the committee chairmen of Children and Youth, Health Careers, Legislation, Membership, and AMA-ERF. Here again, National Chairmen and State Chairmen from the Southern Region met and discussed problems and the best way to get the job done. Wonderful, Wonderful!!!

And we are also fresh from the Southwest District meeting in Mobile at the beautiful Grand Hotel in Point Clear. Baldwin and Mobile are the only organized counties in this District but we were fortunate to have two lovely doctors' wives from Clarke County as guests. We hope they will want to join us in our Auxiliary work.

Other District meetings held in October were Southeast in Dothan at the Ramada Inn, we have much work to do in this district as the counties bordering Georgia are not organized in auxiliaries. We are working on them and really need help from the doctors in these counties. Northeast and Northwest Districts held a joint meeting at the beautiful Jetport in the Decatur-Huntsville area. This was our largest meeting and since nearly all the counties have auxiliaries this was a well

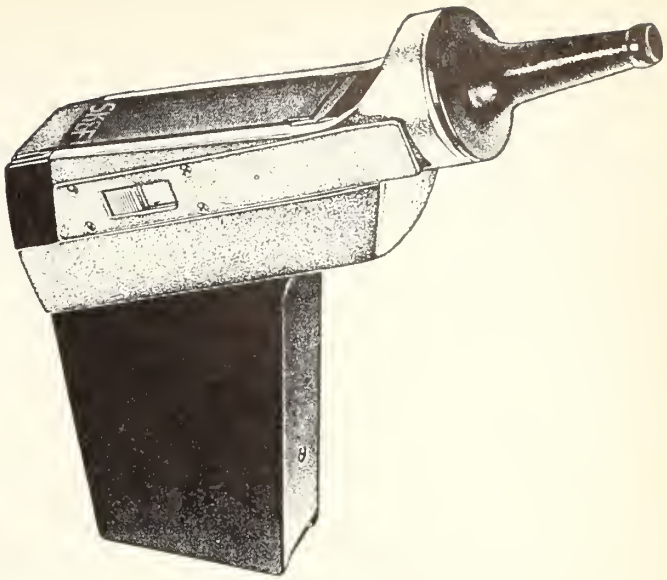
attended meeting. With all of this learning experience you know our gals are well informed and you can expect some really great projects to come out of the counties this year.

And now the really BIG news about the MIST program, this is Medical Information Service via Telephone. This hook-up makes it possible for any of Alabama's doctors to dial directly to the Medical Center, free of charge, for any information personally and quickly. This is the first program of its kind and is attracting much notice nation-wide. There has been good publicity in the Birmingham News and in the October 10 issue of Time Magazine, page 72. Also the January issue of MD's Wife will carry an article about this wonderful program. The Auxiliary is proud to have a part in this unique program for AMA-ERF funds have helped to make this possible. The purchase of expensive equipment as alerting devises (beepers) worn by doctors on call, the WATS line (incoming and outgoing calls), all telephone equipment and a large tape recorder connected to the telephone have all been made possible by this fund. The proof of the pudding is in the eating, and the monthly tally sheets showing the number of calls coming in and the counties using this service indicates there is a definite need and it is being used.

So again, we make our plea, send in your contribution to the AMA-ERF Auxiliary Fund and we will continue to help medical education serve the nation, these funds are unrestricted and since it is OUR money there is no government control. What a great opportunity to further medicine with our $$$$.

Ruth R. Johnson

(Mrs. Ben H. Johnson, Jr.)
President, WAMASA



See more, do more with the new Hotchkiss™ Otoscope

A revolutionary new instrument rather than an improvement over existing equipment, the Hotchkiss Otoscope employs the principles of modern optics to give you a brighter, clearer, more informative view of the ear canal and tympanic membrane. It's also more versatile than ordinary otoscopes—you can use it for diagnostic or operative procedures without making any changes. Yet the five-ounce Hotchkiss is lighter, easier to handle and carry, and every bit as durable as instruments that offer you less.

See for yourself. Clip and mail the coupon, and our Representative will call for an appointment to show you the new Hotchkiss Otoscope in your office.

SK&F Smith Kline & French Laboratories

Smith Kline & French Laboratories E-30 B
1500 Spring Garden Street
Philadelphia, Pa. 19101

I would like your Representative to call for an appointment to show me the new Hotchkiss Otoscope.

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____



Is Organized Medicine Pursuing The Lemming's Course?

When a doctor accepts without challenge the statement that medical care is a right, he's been had. He has no further basis for arguing any man's demand on his time and skill.

Without quotation marks, this thought is lifted from the heart of an editorial predicated on the idea that "organized medicine has been showing some very distinct suicidal tendencies," published in the first issue of a new magazine, *Private Practice.* And it goes ahead to make this pithy point:

"To say that medical care is a right, that a man has the right to be cared for, is to presuppose that he is to be taken care of by somebody. And what of that 'somebody's' rights?"

Background material for the editorial was obtained in a state medical association conference on comprehensive health planning, a "strictly one-sided affair," which he found politically "stacked." One speaker after another made such unchallenged allegations as:

"Health care is a human right—with almost constitutional status," "Good health is not just a privilege—it is really a right," and one speaker said that "The public has a right to expect the health care system to accept the necessary organization and control."

Necessary by whose determination? wonders the editorial. "The doctor's or that of a sociology professor in Decisionville? Who does the controlling? By what right? With what power? On whose authority? (I ask these questions because they were not asked by the doctors at the meeting)."

The president of the state medical association said there are two approaches to health planning: "The end-result approach, which is authoritarian, and the process approach, wherein people with knowledge and expertise become involved in the program. This second way is democratic." This second way, retorts the editorial, is known as "digging your own grave."

But the punch lines are in the closing paragraphs:

'Doctors are showing remarkable forebearance in light of the attempts to take away their freedom of practice.

'Edmund Burke once said: "There is . . . a limit at which forebearance ceases to be a virtue."

'Doctors, your forebearance has ceased to be a virtue.

'To go along with the planners who would tell you what patients to see, what to prescribe, how to practice, what to charge, is not tolerance; to invite the planners to be your speakers and let them go unchallenged is not tolerance; to agree to their demands is not tolerance.

'It's suicide.'

(Continued on Page 436)

Hoechst is proud to be able to offer
nearly 100 years of patient-centered research
to "bridge" the sometimes awesome chasms of medicine.



"Life is short and art is long;
the crisis is fleeting,
experiment risky,
decision difficult."

HOECHST PHARMACEUTICAL COMPANY, Cincinnati, Ohio 45229
Division of American Hoechst Corp.

HOECHST

Major discoveries of Hoechst world-wide research include procaine, arsphenamine, mersalyl, tolbutamide, and furosemide.

(Continued from Page 434)

What Is Meaning of Spread In Gonorrheal Infection?

Is there a rising tide of gonorrheal infection in the world? If so, what are the causes for it? If not, is it reasonable to charge the seeming increase to the earlier reluctance of some physicians to report their cases?

A recent issue of E. E. N. T. Digest accepts the statistics at their face value and lists six reasons for the increase. Frederick S. Wolf, M. D., Director, Bureau of Preventable Diseases, State Health Department, raised a quizzical eyebrow at the translation of these statistics into reasons:

The six reasons listed:

(1) Venereal disease has a short incubation period (1 to 3 days).

(2) Infection is frequently asymptomatic in females. (Dr. Wolf adds: "and males").

(3) Moral standards of the population are probably changing.

(4) Epidemiologic control is hampered by the reluctance of physicians to report cases.

(5) The gonococcus is developing relative resistance to penicillin.

(6) The germ has low antigenicity which accounts for the lack of immunity, the absence of a preventive vaccine, and the difficulty in developing a satisfactory biologic test for infected individuals. It is therefore not surprising that some institutions are experiencing rising rates of gonococcal conjunctivitis in newborns.

This year's statistics will probably show a 600 increase in gonococcal infection in Alabama, Dr. Wolf said, adding that there was no way to determine if this demonstrated an increase in infection or a more diligent reporting of new cases, for "doctors are reluctant to report, in many instances."

Dr. Wolf expects a reduction in primary and secondary syphilis for this year, but declined to elaborate at this time, pending the national report later in the year. He agreed that more massive doses of penicillin are required for the treatment of gonorrhea than formerly, which could indicate growing resistance.

Under Alabama law, silver nitrate (or a current replacement, penicillin) is used immediately after birth to combat gonococcal conjunctivitis, so there is no way of accurately checking a rising rate in this State.

Dr. Wolf doubted that these statistics could be used to measure changing moral standards in the nation today.

The bare statistics will bolster neither side of the continuing debate on moral turpitude. But they will be of interest to both sides.

Ec-
on-
omy!
Dicarbosil®
ANTACID
Your ulcer patients and others will appreciate it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.
ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

It Is Also a Month Significant to Medicine

"Thirty days hath November. . . "

So begins the piece of doggerel that, until the calendar is changed, will key many Americans to the number of days in each month of the year.

Because November is the month of blood and death doesn't mean that it is the month that the spotlight turns searchingly on the caduceus. Somewhere back in forgotten history it was dubbed the blood month because, in cooler climes, it was the month when animals were slaughtered for the winter's meat supply. It is known as the month of death simply because the sap retreats from the outer branches of plant life, the autumn-colored leaves fall from the trees, and nature hibernates for the winter.

But November is also the calendar's greatest misnomer. *Novem* is the Latin word for nine, for November was once the ninth month. When the calendar was revised, one new month was named for Julius Caesar, another for Augustus Caesar. It was urged that the onetime ninth month be renamed for the second Emperor of Rome, Tiberius Caesar. But that monarch modestly rejected the suggestion, saying: "What will you do if there are thirteen Emperors?" So the ninth month became the eleventh month with its name unchanged.

November is the birth month of Frederick Grant Banting, who discovered insulin; of Marie Sklodowska Curie, who with her husband discovered radium; of Leo H. Baekeland, discoverer of synthetic resin; of William Beaumont, the American surgeon famous for study of the stomach and digestion; of John Harvard, English clergyman for whom was named a New England school which has graduated numbers of Alabama doctors in practice today.

Nov. 12th is the birthdate of an M. D. who turned from the diligent practice of medicine to the militant practice of politics, overthrowing an ancient imperial dynasty to rule over China in its stead. Dr. Sun Yat-sen, founder and first president of the Chinese Republic, married one of the famous Soong sisters, which made him a brother-in-law of his successor, Chiang Kai-shek.

So November—the "blood" month, the "death" month—is also a month significant in the progress and practice of medicine.

To Make The Rats Less Fertile

One dose of a new chemical which leaves male rats healthy, energetic, aggressive—and permanently sterile—is the laboratory's latest answer to the wild-rat population menace.

The sterile rat retained in a population should exert a much greater control than if the same number of fertile individuals was removed, since these sterile rats can continue to compete for territory, food, social order, and sexual partners.

Sterilization of males has been successful in controlling screwworm fly populations and other species of insects, while "the pill" is proving effective in the problem of multiplying pigeons.

The rat sterilization formula is a product of the Upjohn Company, Kalamazoo, Michigan.

---

100 Medical Freshmen

The largest freshman class in the 25-year history of the Medical College, University of Alabama, Birmingham, is now studying. With 100 enrolled it represents an increase from 85 of two years ago, and from 80 in 1966. University of Alabama graduates account for 52 of the 100, Auburn for 22.

Fathers and Sons in Medicine

The Doctors Hughes Kennedy of Birmingham

Like father, like son, is a principle no better reaffirmed than in the instance of Hughes Kennedy III, M. D.

Like his father he was born in Birmingham, attended public school in the Magic City, went on to the University of Alabama for his baccalaureate, earned his M. D. at Harvard, made Pediatrics his specialty, returned to his native city to practice, and appropriately shares offices with his father under the partnership name of Drs. Kennedy & Crittenden, Pediatrics. Their associate is William C. Crittenden, M. D., also a native Alabamian.

The senior Kennedy—who is more accurately the junior, as his son is the 3rd and his grandson the 4th—saw a war intervene between his A. B. degree and his M. D. He served in the Army's Medical Reserve from 1917 to two months after the Armistice, to January, 1919.

He was married to Leona Esther Pipes in the Little-Church-Around-the-Corner, New York City, Jan. 2, 1922, and they have two other children, William Henry Kennedy, married to the former Lorna Craddock of Ogden, Utah, where they presently reside with their four children; and a daughter, Jeanette Corman Kennedy, who is now Mrs. James Hughes Hancock, whose husband is a native Montgomerian. The Hancocks, parents of three children, live in Birmingham.

Dr. Kennedy, Jr., has been Director of Child Health, Birmingham Public Schools, since 1966; is a past President of the Jefferson County Medical Society, of the Alabama Pediatrics Society, of the Birmingham Medical Round Table, and of the Birmingham Clinical Club; is a past Chairman of the Pediatric Section, Southern Medical Association, of the Alabama State Chapter, American Academy of Pediatrics; a MASA Life Counsellor, and a Fellow and Life Member of the American Academy of Pediatrics, as well as past Chairman of the Alabama State Chapter, American Academy of Pediatrics.



Drs. Hughes Kennedy

Dr. Kennedy III is a member of all the same professional societies and social clubs as his father before him, is a past President of the Alabama Foundation for Hearing and Speech, and is Chairman of the Committee on Maternal and Child Health of the Medical Association of the State of Alabama.

Father and son have made Pediatrics a hobby as well as a specialty, but the father

(Continued on Page 441)



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

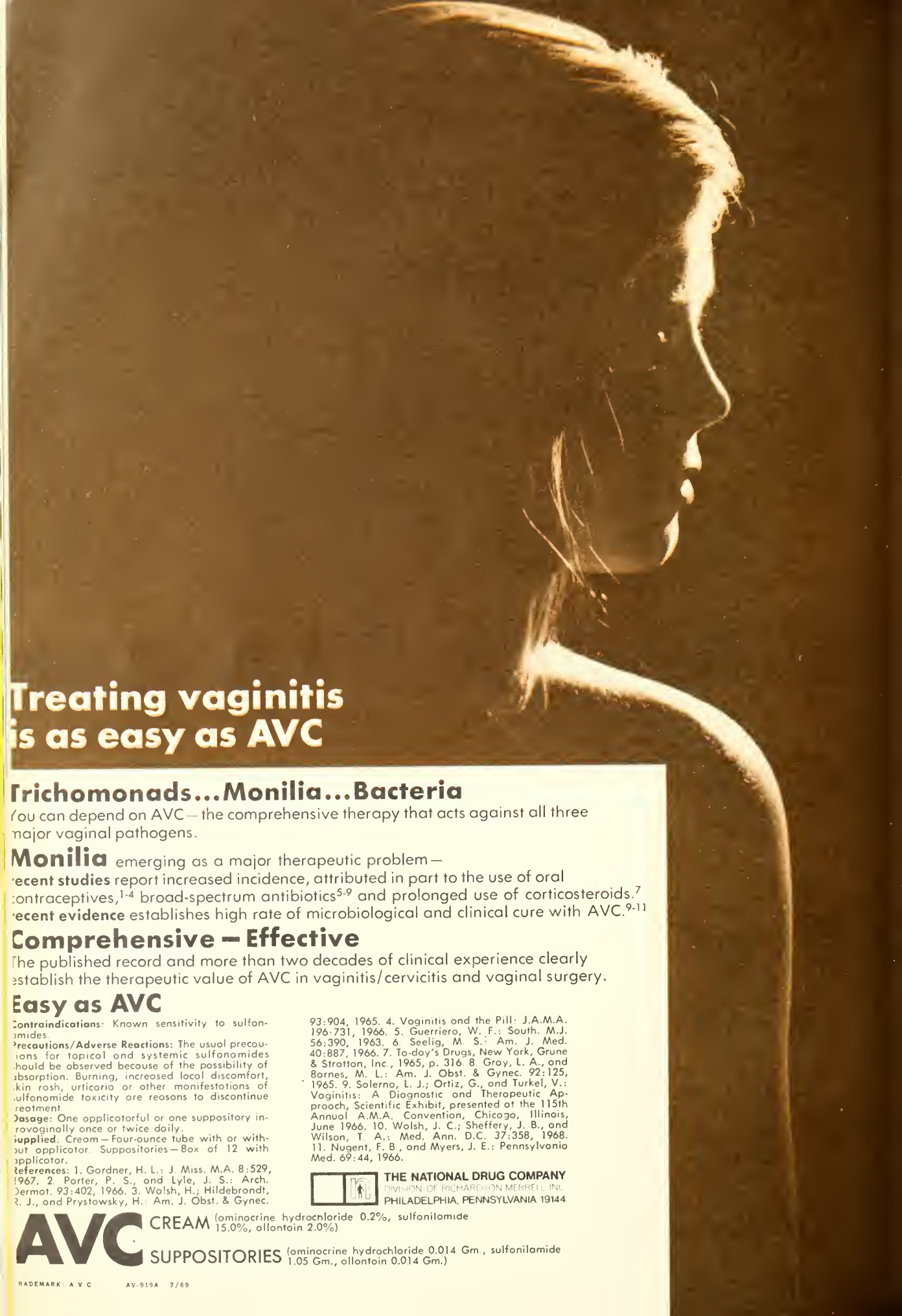
Prescribing Infarmation—Camposition: Each white, beveled, campressed tablet cantains: Quinine sulfate, 260 mg., Aminaphylline, 195 mg. **Indicatians:** Far the preventian and treatment af nacturnal and recumbency leg muscle cramps, including thase associated with arthritis, diabetes, varicose veins, thrambaphlebitis, arteriosclerasis and static faat defarmities. **Cantraindications:** QUINAMM is contraindicated In pregnancy because af its quinine cantent. **Precautions/Adverse Reactions:** Aminaphyllline may produce Intestinal cramps In same instances, and quinine may praduce symptams af cinchanism, such as tinnitus, dizziness, and gastraintestinal disturbance. Discantinue use if ringing in the ears, deafness, skin rash, ar visual disturbances accur. **Dasage:** One tablet upan retiring. Where necessary, dasage may be increased ta ane tablet fallawing the evening meal and ane tablet upan retiring. **Supplied:** Bottles af 100 and 500 tablets.



THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps



Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC — the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem —
Recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
Recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive — Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfonamides.
Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.
Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream — Four-ounce tube with or without applicator. Suppositories — Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Voginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. Today's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Solerno, L. J.; Ortiz, G., and Turkel, V.: Voginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

AVC CREAM (ominocrine hydrochloride 0.2%, sulfonilomide 15.0%, allantoin 2.0%)

SUPPOSITORIES (ominocrine hydrochloride 0.014 Gm., sulfonilamide 1.05 Gm., allantoin 0.014 Gm.)

TRADEMARK: A V C

AV-919A 7/69

(Continued from Page 438)

now easing up enough to travel a bit—to urope, the Orient, and Alaska.

When it comes to hobbies other than his ecialty, however, it is like uncle, like son. or the younger Dr. Kennedy is a board ember of the Birmingham Festival of Art, a past Chairman of the Sidewalk Art Show, id of the Religious Art Show at the Bir- ingham Museum of Art; though also ad- itting a liking for Gardening, Cooking, ooks and Art Collecting.

His Uncle Walter Kennedy, a younger brother of the senior Dr. Kennedy, retired President and Board Chairman of the First National Bank of Montgomery, is a gifted artist who has traveled as far away as Spain to commit to canvas the scenes that impressed him.

An appreciation dinner paying to "Benjamin Hughes Kennedy, Jr., M. D. for his forty-two years of loyal and devoted service to The Children's Hospital—for his magnificent contributions as a pediatrician and citizen, to his city, county and state, and for his living example of medical ethics," honored him in 1965, hosted by the Children's Hospital.

The Selden Harbour Stephens, Sr. and Jr.

The first of this long-established Alabama mily destined for a career in Medicine was rn Aug. 17, 1898, at Keener, Ala., took his e-med work at the University of Alabama, 17-19, and was graduated with an M. D. de- ee from Emory in 1923. He interned first Grady, Atlanta, and then at Mobile Gen- al Hospital. After two years of Public ealth work with the U. S. Marine Hospital, obile, he entered general practice in the rt City, continuing to March 1958, when retired.

Married to Mabel Mosteller, the Selden arbour Stephens now have two sons and ne grandchildren. Mosteller Stephen heeler now resides with his family in Eu- ne, Ore.

The other son, Stephen, Jr., was born June 1929, in Mobile, received his elementary ucation in the Mobile public schools, his S. degree from Virginia Military Institute, d was graduated from the University of abama Medical College in 1953. Interning a year at the University Hospital in Bir- ngham, the younger Dr. Stephens took his r of duty as a captain in the Air Force, st of his three years stationed at Rebat, rica, before returning to University Hos- al for three years' residency in Ob-Gyn. has been in private practice since 1960.



The two Drs. Stephens with Selden Harbour Stephens III

Married to the former Jane McKinnon of Troy, the junior Stephens have four children —Ann Brockman, Selden Harbour III (who is 9 years old, the picture above being taken some years ago), Thornton McKinnon, and Cameron Mosteller.

(Continued on Page 445)

THE BREAKUP of a business partnership, the crack-up of a marriage, the shake-up of being fired or reduced to bankruptcy... after any significant loss or severe blow to self-esteem, *both* anxiety and depression almost always follow.



FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCl

For prescribing information, including indications, contraindications, warnings, precautions, and side effects, please see following page.



FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCl

TRIAVIL®2-25: Each tablet contains 2 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®4-25: Each tablet contains 4 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®2-10: Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

TRIAVIL®4-10: Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; urinary retention; pregnancy; glaucoma. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least 2 weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory response.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be potentiated.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed,as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

SIDE EFFECTS: Similar to those reported with either constituent alone.

Perphenazine: Should not be used indiscriminately. Use caution in patients with history of convulsive disorders or severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; severe acute hypotension (of particular concern in patients with mitral insufficiency or pheochromocytoma); skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); grand mal convulsions; cerebral edema; altered cerebrospinal fluid proteins; polyphagia; paradoxical excitement; photophobia; skin pigmentation; failure of ejaculation; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia; significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol), atropine, heat, and phosphorous insecticides.

Amitriptyline: Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypotension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, blurring of vision, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

For more detailed information consult your Merck Sharp and Dohme representative or see the package circular.

MSD | **MERCK SHARP & DOHME**
Division of Merck & Co., Inc., West Point, Pa 19486
where today's theory is tomorrow's therapy

(Continued from Page 441)

The Goldsteins of Montgomery

From the Cradle of the United States (Philadelphia) to the Cradle of the Confederacy (Montgomery) is a distance to move, but a young Doctor made the move, arriving by way of New Orleans, and bringing with him his wife, his daughter, and his son, with whom he is the subject of this father-and-son article.

Born in Philadelphia May 4, 1914, Howard Goldstein earned his baccalaureate at Temple University 19 years later, his M. D. from Temple in 1937. A three-year tour of duty in the Medical Corps (1942-45) was sandwiched between his internship at St. Luke's Medical Center, Philadelphia, and his residency in Radiology at Touro Infirmary, New Orleans. A Fellowship in Radiation Therapy at Charity Hospital, New Orleans, preceded his move to Montgomery in 1948.

Gordon T. Goldstein was born in Philadelphia April 3rd, 1942, graduating from Sidney Lanier High in Montgomery 17 years later, earning his baccalaureate degree from the University of Alabama in 1963, his M. D. from the University of Alabama Medical College, and is now serving his internship at Emory University Hospital, Atlanta. It is probable that he will follow in his father's footsteps with a residency in radiology.



The Drs. Goldstein

The senior Dr. Goldstein is married to the former Florence Felt of Philadelphia, and their second child, Sandi (now Mrs. Jules Stein of Atlanta), also was born in the Pennsylvania city. Two younger sons, Warren and Craig, 17 and 16 respectively, were born in Montgomery.

Reading is Dr. Howard Goldstein's hobby.

Library Of Suicidology

A "Basic Library on Suicidology," published by the Mental Health Materials Center, Inc., New York, is being made available for distribution to psychiatric facilities and all other mental health programs with a direct interest in suicide-prevention activities. This Basic Library, organized into a packet consisting of 10 books, 12 pamphlets, a playscript, and reviews of several recommended films, is designed to serve as a basic bibliographic source.

In Battle On Breast Cancer

Teslac, an entirely new compound, found effective in 13 per cent of advanced or disseminated mammary cancer, is being introduced by Squibb, for use in post-menopausal women when hormonal therapy is indicated.

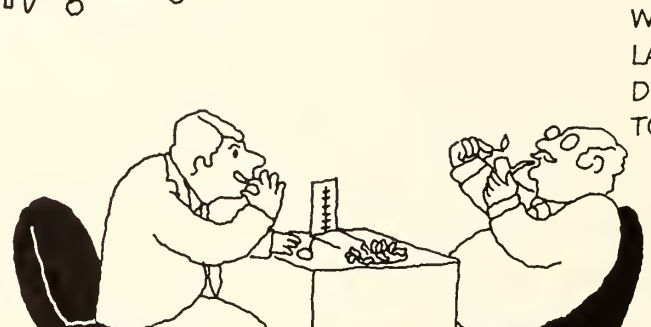
Castration either by surgery or radiation is recommended prior to initiation of therapy with Teslac, and according to distributors of the compound, it is intended to replace neither surgery nor irradiation therapy in local or early disease.

The Apprehensive Hypertensive



WELL, YOU HAVE WHAT WE CALL MODERATE HYPERTENSION— HIGH BLOOD PRESSURE. NOW I DON'T WANT YOU TO WORRY, BUT WE ARE GOING TO HAVE TO CHANGE A FEW LIVING HABITS. FIRST, WE'RE GOING TO HAVE TO CUT OUT SMOKING-ALTOGETHER.

THEN WE HAVE TO LOSE WEIGHT. 20 POUNDS SHOULD DO IT... WE'LL TALK A LITTLE LATER ABOUT THIS DIET WE'RE GOING TO START.

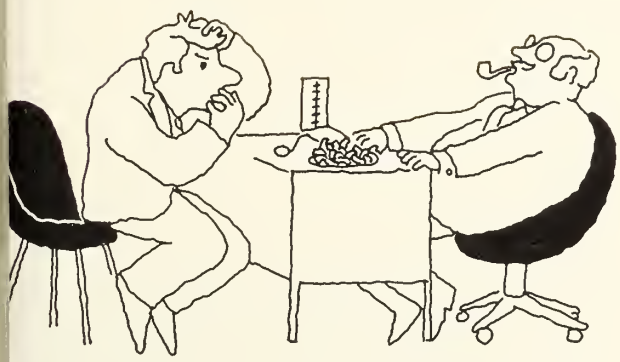


Regroton® to lower blood pressure

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Regroton®: chlorthalidone 50 mg., reserpine U.S.P. 0.25 mg. *Indications:* Hypertension. *Contraindications:* History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. *Warning:* With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. *Precautions:* Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving

WE'VE GOT TO GET PLENTY OF REST AND TRY TO AVOID SITUATIONS THAT MAKE US ANXIOUS OR TENSE. AND WE'LL TAKE MEDICINE TO LOWER OUR BLOOD PRESSURE AND CALM US DOWN.



WE'VE GOT PROBLEMS.



and allay anxiety in hypertension

corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. *Adverse Reactions:* The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. *Average Dosage:* One tablet daily with breakfast. *Availability:* Pink, single-scored tablets in bottles of 100 and 1000. (B)46-600-C

For details, please see complete prescribing information.

Regroton®
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

RE-6742

Rubella Vaccine Recommendations

The attached statement on rubella vaccine recommendations was prepared for the information and guidance of the medical profession.

The Council on Environmental and Public Health suggests that the statement be publicized among your physician membership and encourages their support to the program of rubella vaccination.

Background Information

While rubella (German Measles) is generally a mild disease when contracted during childhood, in postpubertal individuals, particularly females, there is considerably greater potential for harm. The illness is often more serious and prolonged and not infrequently has complications such as arthritis, arthralgia, and rarely, encephalitis. In addition, when rubella is present during pregnancy, especially during the first trimester of pregnancy, but also during the second trimester, from 15 per cent to 35 per cent of the infants may be born with what is now known as the congenital rubella syndrome. This includes partial or total loss of hearing or vision, major heart defects, mental retardation or combinations of these defects. In addition, there is a significantly increased proportion of miscarriages and stillbirths. Thus, serious transplacental damage is done by the virus.

The incidence of rubella shows a seasonal increase in the spring, generally during March, April, and May, in the United States, and these seasonal increases, in turn, have superimposed on them major national and international (increases) epidemics occurring at irregular intervals of from approximately six to nine years each. During the last forty years, there were three exceptionally high pandemic peaks that occurred about 1934 and 1935, 1942 and 1943, and 1964.

The primary goal of rubella vaccination is the prevention of the congenital rubella syndrome, with secondary goals of preventing rubella in postpubertal patients where disabilities are usually more serious than the relatively mild disease that it causes in young children.

Vaccine Development

In June, 1969, the first rubella vaccine was licensed in the United States. This was an attenuated live virus, manufactured by Merck, Sharp and Dohme. It is made from the HPV-77 strain that has been grown on duck embryo cell culture. This vaccine was tested on over 13,000 susceptible children prior to licensing, with essentially no adverse reactions, although transient arthralgia or arthritis and rash did occasionally occur in older patients.

Smith, Kline and French are currently manufacturing an attenuated live virus rubella vaccine from a different strain (Cendehill). This is grown on rabbit kidney cell culture in Belgium and probably will be licensed in the near future in the United States. There is a similar expectation for an attenuated live virus vaccine that has been grown on dog-kidney cell culture by Phillips-Roxane. In addition, experimental work is progressing at the Wistar Institute in Philadelphia with a still different virus strain (WI-38), which is being grown on human embryo lung cell culture (Diploid cell). Thus, it is very likely that prior to the next seasonal peak, which would be anticipated in spring, 1970, millions of doses of at least three different rubella vaccines will be available for use in the United States.

It is known that, following vaccination, virus particles are shed from the nasopharynx and uterine cervix. However, there have been no reports of cases of rubella as a consequence of the shedding.

Vaccine Administration

The currently licensed vaccine is administered by a single subcutaneous injection of

(Continued on Page 453)

now he can cope...



hanks to

Butisol SODIUM®
SODIUM BUTABARBITAL)

he "daytime sedative" for veryday situational stress

hen stress is situational—environmental pressure, orry over illness—the treatment often calls for an nxiety-allaying agent which has a prompt and redictable calming action and is remarkably well lerated. Butisol Sodium (sodium butabarbital) eets this therapeutic need.

fter 30 years of clinical use . . . still a first choice nong many physicians for dependability, safety and onomy in mild to moderate anxiety.

ontraindications: Porphyria or sensitivity to arbiturates.

recautions: Exercise caution in moderate to severe epatic disease. Elderly or debilitated patients may act with marked excitement or depression.

dverse Reactions: Drowsiness at daytime sedative ose levels, skin rashes, "hangover" and systemic sturbances are seldom seen.

Varning: May be habit forming.

sual Adult Dosage: As a daytime sedative, mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

vailable for daytime sedation: Tablets, 15 mg. (¼ gr.), mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

UTICAPS® [Capsules Butisol Sodium (sodium butabarbital)] mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

cNeil Laboratories, Inc., Fort Washington, Pa.


No place for beginners

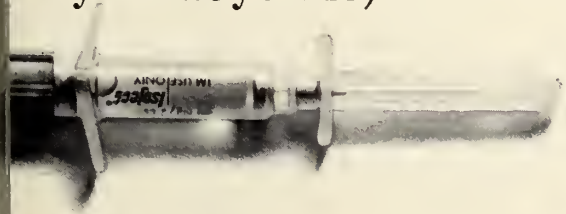
Terramycin®
(oxytetracycline)

Fire victim. Examination reveals second degree burn of lower leg. To combat shock, restore circulatory volume and replace protein loss, plasma is administered. Local pressure dressing applied. Limb elevated to limit the flow of lymph. About 36 hours after admission the patient develops an elevated temperature and complains of pain at the site of the lesion. Dressing removed. A suppurating slough area has developed over part of the burn. A swab specimen is taken for culture and the slough area is debrided. Antibacterial treatment is begun with Terramycin I.M. Days later, recovery is progressing, and the laboratory report shows a mixed infection with a predominance of susceptible coliform bacteria, confirming the therapeutic choice. Terramycin therapy is continued until all signs of infection disappear.

Experience has shown that Terramycin offers special advantages in treating bacterial infections complicating burns, when strains of causative organisms are susceptible. Broad-spectrum antibacterial coverage. Activity unaffected by penicillinase. Rapidly achieved therapeutic blood levels. Proven tissue toleration.

Terramycin I.M. is the only preconstituted broad-spectrum antibiotic designed specifically for intramuscular use. Requires no refrigeration. Remains stable for at least two years. Available for immediate use in Isoject,® a disposable injection unit. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Terramycin® I.M.
(oxytetracycline)



Pfizer **LABORATORIES DIVISION**
New York, N.Y. 10017

Contraindicated: In individuals hypersensitive to any of the components of this drug.

Warnings: If renal impairment exists, even usual doses may lead to excessive systemic accumulation and possible liver toxicity. In such patients, lower than usual doses are indicated and for prolonged therapy oxytetracycline serum level determinations may be advisable.

Terramycin may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight. Discontinue therapy at first evidence of skin discomfort.

Note: With oxytetracycline, phototoxicity is not believed to occur and photoallergy is very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy.

As with all intramuscular preparations, Terramycin Intramuscular Solution should be injected well within the body of a relatively large muscle. *Adults:* The preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. *Children:* It is recommended that intramuscular injections be given preferably in the mid-lateral muscles of the thigh. In infants and small children the periphery of the upper outer quadrant of the gluteal region should be used only when necessary, such as in burn patients, in order to minimize the possibility of damage to the sciatic nerve.

The deltoid area should be used only if well developed such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Increased intracranial pressure with bulging fontanelles has been observed occasionally in infants receiving therapeutic doses of the drug, but such signs and symptoms have disappeared rapidly on cessation of treatment with no sequelae.

Adverse Reactions: Subcutaneous and fat-layer injection may produce mild pain and induration which may be relieved by an ice pack. Very mild gastrointestinal disturbances, not requiring discontinuance of the drug, may occur occasionally. Allergic reactions, including anaphylaxis, rarely have been observed.

Dosage: *Adult:* The optimal dosage varies, depending on the type and severity of infection. Unless otherwise specified, a dose of 100 mg. every 8 to 12 hours, or a single daily dose of 250 mg. should be adequate for the treatment of most mild or moderately severe infections. In severe infections, 100 mg. every 6 to 8 hours, or 250 mg. every 12 hours may be necessary.

Serum levels obtained by the recommended dosages are comparable to those provided by the oral dosage of 1 to 2 Gm. daily in adults. Antibiotic therapy should be continued for at least 24 to 48 hours after all symptoms and fever have subsided.

In certain diseases specific courses of therapy may be recommended as a general guide. In primary and secondary syphilis for example, the daily administration of 2 Gm. oxytetracycline, orally, in divided doses for two weeks has given good results. In cases of gonococcal infection two intramuscular injections of 250 mg. each, or one intramuscular injection of 250 mg. combined with one gram given orally as a single dose, will usually suffice, but repetition of this therapy will be required in an occasional case.

In the treatment of hemolytic streptococcal infections, therapy should continue for at least 10 days to prevent development of rheumatic fever or glomerulonephritis.

In the treatment of staphylococcal infections indicated surgical procedures should be carried out in all cases.

Pediatric: A dosage of 3 mg./lb./day in two doses has been found satisfactory in the treatment of most mild to moderately severe infections. For more severe infections, higher dosages may be indicated and should be adjusted accordingly.

Terramycin Intramuscular Solution provides maximum absorption and patient toleration with minimal local irritation.

Supply: Terramycin (oxytetracycline) Intramuscular Solution: available in single dose, prescored glass ampules containing 100 or 250 mg. oxytetracycline/2 cc. Isoject® syringes containing 100 or 250 mg. oxytetracycline/2 cc. and 10 cc. multiple dose vials containing 50 mg. oxytetracycline/cc.

More detailed professional information available on request.

this ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement to facilitate healing in chronic cutaneous ulcers...

Elase® ointment

(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

PARKE-DAVIS

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

48168

(Continued from Page 448)

reconstituted lyophilized vaccine. The label and insert instructions should be carefully read and followed. The following precautions are recommended.

Pregnant women must not be given the vaccine because the viremia that follows vaccination and lasts two to six weeks may permit the virus to pass the placental barrier and affect the growing fetus.

If vaccination of a nonpregnant woman in the childbearing age is anticipated, special safeguards should be taken. These might include testing the woman to make sure she is not already immune to rubella* and would include carefully weighing the advantages of vaccine administration against the disadvantages, including the possibility of her becoming pregnant, with the likelihood that the fetus might miscarry or develop the congenital rubella syndrome. If the physician believes that vaccination is desirable, he should prescribe a medically acceptable method for contraception and should explain the potential risk of becoming pregnant to the patient, and, preferably, obtain written, informed consent for the vaccination.

Because of the possibility of placental transfer of maternal immune bodies and the likelihood of these interfering with the development of immunity following vaccination, it is recommended that the vaccine not be administered to children under one year of age. The presence of other virus diseases or any febrile active generalized infection, as well as the use of corticosteroids, irradiation, alkylating agents or antimetabolites or other agents that would weaken the normal defense mechanisms of the individual are contraindications to the use of rubella vaccine. Other contraindications include concurrent use of a different live virus vaccine (eg. measles or poliomyelitis). Administration of the rubella vaccine should then be deferred for at least four to six weeks.

For the Merck, Sharp and Dohme vaccine (Lyovac-Meruvax), epinephrine should be available for immediate use in case of an anaphylactoid reaction. The vaccine (which is grown on duck embryo cell culture) should not be given to individuals who are sensitive to duck or chicken eggs or feathers and, inasmuch as each dose of the reconstituted vaccine contains 25 micrograms of neomycin, individuals sensitive to this drug should not receive vaccine.

General Recommendations

Inasmuch as the vaccine currently available in the United States is still relatively new (about 13,000 susceptible children had been observed for adverse reactions prior to licensing), it is possible that unanticipated adverse reactions, particularly in older patients, may occur with the general use of the vaccine. Therefore, it is recommended that any serious adverse reactions be reported promptly to the State Health Department and to the manufacturer who is responsible for reporting it to the Division of Biologic Standards of the National Institutes of Health.

While the frequency of naturally acquired immunity varies considerably with the age of the patient and the incidence and prevalence of the disease in a particular community, the National Communicable Disease Center estimates that about 15 per cent of the children under five years of age have become immune through naturally acquired disease, and that for the other age groups the respective natural immunity levels are approximately 35 per cent for the five to nine year olds, 60 per cent for the ten to fourteen year olds, 75 per cent for the fifteen to nineteen

(Continued on Page 455)

* The only reliable evidence of immunity is a positive serological test. However, because of the variation among reagents and technical procedures, results of serological tests should be accepted only from laboratories of recognized competency that regularly perform these tests.

When trauma results in pain, try Norgesic first... your patients probably won't need anything stronger

Sprains, strains, fractures... NORGESIC offers predictable relief in the great majority of traumatic injuries where both pain and muscle spasm are involved. Unlike "pure" analgesics or muscle relaxants, NORGESIC affects both components of musculo-skeletal pain, providing effective analgesia and relief of associated muscle spasm.

NORGESIC works quickly, usually producing a high level of analgesia within two hours, and relief is sustained for four hours or longer. Thus, when trauma results in pain, try NORGESIC first... your patients probably won't need anything stronger.

Indications: Symptomatic relief of mild to moderate pain of acute musculo-skeletal disorders. Here, NORGESIC demonstrated clinical superiority to APC as an analgesic.

Contraindications: Because of the mild anticholinergic effect of orphenadrine, NORGESIC should not be used in patients with glaucoma, pyloric or duodenal obstruction, achalasia, prostatic hypertrophy, obstructions at the bladder neck, myasthenia gravis and in patients known to be sensitive to aspirin, phenacetin or caffeine. Do not use propoxyphene (Darvon®) concurrently.

Warnings: USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the childbearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child. USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

Precautions: It has been reported that prolonged or excessive use of phenacetin may result in nephrotoxicity. Caution, therefore, should be exercised when NORGESIC is administered to patients with renal disorders.

Adverse Reactions: Side effects of NORGESIC are those usually associated with APC or mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, some degree of confusion in the elderly, mild central excitation and occasional hallucinations. These mild side effects are usually eliminated by reduction in dosage. One case of aplastic anemia, with no established causal relationship, has been reported.

Dosage and Administration: Adults—1 to 2 tablets 3 to 4 times daily.

For more detailed prescribing information, see Package Circular or PDR.

Available V.A. Supply Depot—FSN6505-952-6762A



NORGESIC®

(orphenadrine citrate, 25 mg., aspirin, 225 mg., phenacetin, 160 mg., caffeine, 30 mg.)

Riker Laboratories, Northridge, California 91324

Sponsors of Riker Service— the complimentary classified service for physicians.

(Continued from Page 453)

year olds, and 85 per cent to 90 per cent for those twenty to thirty-nine years old.

These figures vary from community to community, but may be used as a general guide for the desirablity of performing screening tests for susceptibility prior to giving the vaccine. However, each person should be evaluated on an individual basis whenever possible.

For widespread use, in view of the lack of adverse reactions in small children and the fact that about two-thirds of the children under ten would be susceptible, all should receive the vaccine without doing a preliminary serological test for susceptibility. Children in kindergarten and the early grades of elementary school deserve initial priority for vaccination because they are commonly the major source of virus dissemination in the community. A history of rubella illness is usually not reliable enough to exclude children from immunization.

In view of the fact that circumstances will differ in various localities, it is recommended that group programs and public health programs should be launched on the basis of a coordinated plan, developed jointly by state and local public health agencies in cooperation with state and local medical and osteopathic associations.

Heart Disease Crippler No. 1

Heart conditions lead the field in limiting the activities of the chronically ill, with arthritis and rheumatism in a challenging second place, among the 67,000 Kentuckians "not residing in institutions who are limited or impaired so severely that they are unable to carry on their usual major activity," according to a survey published in a recent issue of the Journal of the Kentucky Medical Association. The article carries the byline of David L. Kruegel, Ph.D., lecturer, University of Kentucky Department of Sociology, Lexington.

The AMA Convention of 1869

By

Howard L. Holley, M. D.

At the close of the Civil War there was a general feeling among the medical profession of the former Confederate States that they should identify themselves again with their colleagues in the American Medical Association.

The attitude of the medical profession, i. e., those representative of the Northern States and as reflected in the Transactions of the American Medical Association reveals little of the bitter sectional feeling that was widespread and was often ascribed to some professions and societies.

Although no meeting of the American Medical Association was held in 1861 and 1862, AMA records for the war period still listed permanent members residing in the Southern States.

In 1868 a large number of physicians from all over the South attended the annual AMA meeting in Washington, D. C. On May 7, 1868, Dr. William Owen Baldwin of Montgomery, Alabama, was elected president. This honor was partly to honor such an outstanding physician as Dr. Baldwin, but unquestionably it was in part a gesture of good will to the returning Southerners. Dr. Baldwin responded with an acceptance speech in which he welcomed the reunification of the profession. As further evidence of good will, the 1869 Annual Session of the AMA was held in New Orleans, Louisiana.

In his presidential address among other things he discussed the subject of medical education, one of the main objectives of the American Medical Association. He pointed out the lax system of medical education now tolerated in this country to the European System. In the reform of the American System he urged the establishment of "a uniform and elevated standard of requirements for the degree of doctor of medicine." He advocated the establishment of one or more national medical schools to be supported at least in part by the Federal Government.

His recommendation for faculty was that the best possible teachers be obtained for professors and that they must have evidence of high qualifications in learning and *have a fully demonstrated capacity for teaching.* He also suggested that the salaries be large enough to attract the most eligible candidate and that his salary be not dependent on the number of students attending the school!

Dr. Baldwin asked that he be allowed to make a few closing remarks just prior to the end of the session of 1869. His statements were all chosen to further heal the sectional strife:

> "Yet to cherish and promote the intimate and cordial relation of friendship between the individual members of this association against all sectional distinction or geographical lines has also been among the chief objects of my ambition and the earnest desire of my heart."

Reference

1. Carmichael, E. B., William Owen Baldwin: Annals of Medical History, S. 3, V. 4, 1942, pp. 521-531.



The Bradley Center --- for the problems of living

An all new homelike open psychiatric residence on a lovely five-acre tract, centrally located within the community, providing a comprehensive range of continuous services, including in-patient, day care, and outpatient treatment. Each patient participates in an extensive and intensive treatment program, based almost exclusively upon multiple psychotherapeutic encounters. These include individual psychotherapy, group psychotherapy, the nursing milieu, occupational therapy, recreational therapy, topical small group discussions, and other group activities in the Center, as well as in the community, depending on individual needs and interests. Medications are prescribed when appropriate.

Any individual may be admitted who, in the opinion of the medical staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible family member.

Accredited by the Joint Commission on Accreditation of Hospitals.

Leonard T. Maholick, M. D.
Medical Director

Maj. Gen. (ret.) Howard Snyder
Administrator

THE BRADLEY CENTER, INC.
2000 Sixteenth Avenue
Columbus, Georgia 31901
Area Code 404 324-4882



The many forms of Ilosone®

Erythromycin Estolate

Lilly

Additional information available upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

900541

THE JOURNAL

of

THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

Published Under the Auspices of the Board of Censors

Volume 39 November, 1969 No. 5

Physiological and Psychological Evaluation Of The Estrogen Deprived Patient

By

O. Thomas Bolding, M. D. and Herman C. Willcutt, Ph. D.

Birmingham, Alabama

The loss of the normal source of estrogen in mature women usually induces a symptom complex manifested both physiologically and psychologically. This syndrome is more pronounced in some women than in others and can occur in either the relatively young surgical castrate or the older climacteric woman without replacement therapy. It has been our experience, as well as that of others,[1] that estrogen replacement therapy will not only ameliorate many of the familiar physiological complaints but also bring about a generalized feeling of well-being in the treated patient. This feeling has been reported to be one of the most difficult to measure but one of the most important benefits of estrogen replacement therapy to the climacteric patient.[2]

A preliminary report of a study utilizing a Hospital Adjustment Scale[3] has shown that with estrogen replacement, the psychological deterioration in older women can be altered and mental improvement achieved as indicated by certain categories of the Scale. Our purpose in this study of a relatively small number of patients was to evaluate the effects of estrogen replacement in any deprived patient with emphasis on detectable personality changes. These changes were to be determined by use of the Minnesota Multiphasic Personality Inventory (MMPI). Previous experience with this Inventory in overweight patients[4] and reports of other preliminary studies prompted us to undertake this project.

We began our program by enrolling 50 private patients ranging in age from 28 to 67 years. A like number of this group fell above as well as below 45 years of age with the number of surgical patients (88 per cent) predominating. A fairly equal number of patients began the study on each of three dosage ranges of a conjugated estrogen*. Eighteen began on 1.25 mg. daily, 17 on 0.625 mg.

*Menest® supplied by The S. E. Massengill Company.

daily and 14 on 0.3 mg. daily. Only one patient started on 2.5 mg. daily.

Each patient has presently been followed for more than one year with the exception of those dropped from the program. (Table I)

Each patient was taken into the program only after a complete evaluation. We concur with other investigators,[5,6,7] that vaginal cytology alone (Cell Maturation Index) is an inadequate method of evaluating the need for or lack of estrogen in menopausal and perimenopausal women. While closely following this group of women, we were able to determine that in many cases the CMI showed no change corresponding to the improved status of the patient during estrogen replacement therapy. It is now apparent that the CMI should not be used as the single criterion for estrogen evaluation, but only as one part of the total available laboratory and clinical data on the patient. In our practice, the overall response of the patient to estrogen therapy has been a much better barometer of the menopausal storm than has the CMI. This was very evident in our group who have been followed perhaps more closely in all respects than the average patient.

The physiological response has been considered very good in all patients remaining in the program after 12 to 18 months. The somatic complaints of climacteric patients have been reduced by treatment and the majority of surgical castrates have been maintained without difficulty except for necessary dosage changes in some patients. The results of very long term use of exogenous estrogen brought about by relatively early surgery will be interesting to follow. We are continuing to follow 38 of the 50 patients that started our program and periodic evaluation of these patients is anticipated.

Twelve of the 50 beginning patients were either dropped or voluntarily removed themselves from our program. Nine of these were unable to return for follow-up as often as required while only two of the 12 were forced to drop out because of a clear-cut incidence of side effects related to therapy. Nausea

Table I

AGE RANGE	Patients (No.)	Increased Dosage	Surgical Menopause	Natural Menopause	Dropouts
25 - 29	1	1	1	0	0
30 - 34	7	3	7	0	2
35 - 39	10	2	10	0	4
40 - 44	6	2	6	0	0
45 - 49	11	1	8	3	3
50 - 54	2	1	1	1	0
55 - 59	9	1	8	1	1
60 & up	4	1	3	1	2

not improved by dosage adjustment was the primary factor. One 49-year-old woman started the program with readily identifiable symptoms of the menopause and later developed a pelvic mass not thought to be drug related. Exploratory surgery revealed leiomyomata of the uterus and an endometrium with estrin reaction 12th day type. She was considered a "drop" in our evaluation.

Psychological Evaluation

The results of the psychological screening were rather surprising. The MMPI was administered to each patient before starting estrogen therapy in order to obtain base line personality data. The inventory was then repeated at one year. It was anticipated that there would be measurable changes in the psychological adjustment of these patients following a regimen of hormone replacement. This was based on previous observations that a large number of menopausal women report changes in mood or emotional stability corresponding to the variety of somatic symptoms they experience. However, a statistical comparison of the MMPI profiles collected at the onset of the study and those collected after one year yielded no significant differences as a group. This was in contrast to the fact that a large number of the patients reported elevations in mood and a general sense of well-being throughout the course of the study.

As measurable personality changes did not appear in these patients after one year, as determined by their performance on the MMPI, it was felt that certain variables were being masked out by grouping the patients. However, a comparison of the group above 45 years (median age) with the group below and a comparison between natural and surgical menopausal groups yielded no significant differences.

Product moment correlations were obtained between the first and second tests with differences noted in individual cases but with no obvious pattern appearing. The correlations of the various components of this personality scale range from 0.11 to 0.84 with most falling between 0.60 and 0.84 (Table II). The magnitude of these coefficients reflect considerable stability in the characterological and emotional aspects of the group as measured by this test. The exceptions to this high level of stability are found in scales more sensitive to changes in interest, and perhaps reflecting day by day activity. These characteristics have been observed to be much more unstable than others measured by this test.

We did find personality defferences between those patients requiring dosage changes and those not requiring change. Trends in the "Change" group suggested that they were somewhat more immature and dependent upon external factors to meet their emotional needs. As a group they complained more and experienced more somatic symptomatology. They also were somewhat more social, although this was superficial and aimed at getting their needs met. They were more inclined to vocally express feel-

Table II

Test-retest Coorelation Coefficients of the MMPI Scales with an interval of one year

	L	F	K	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si
r	.84	.65	.79	.71	.60	.62	.32	.11	.67	.59	.65	.71	.63

ings of discomfort than the others were. The opposite was true of the "no-change" group who appeared somewhat more withdrawn and apathetic and showed fewer somatic complaints.

Evaluation of MMPI performance between "stay" and "drop" groups also indicated significant differences in some personality characteristics. (Table III) As a group, the "drop" patients appeared more emotionally stable and less defensive about themselves than the "stay" group. It is probable that for the patients who remained a psychological as well as a physical need was being met by continuation in the study that was not present in the "drop" group.

The considerable degree of consistency reflected by the MMPI profile over the course of the year is inconsistent with the patients' reports which were generally of elevations in mood. It is likely that these opposing data were drawn from different levels of the personality structure measured by the MMPI. It is also possible that these negative findings related to measurable personality changes are the result of the experimental technique utilized. Possibly there were measurable changes within these patients early in the treatment period which dissipated as they began to stabilize at their characterological levels, and if this is the case, then the measurement after a year would not reflect those changes. However, the reported changes in mood are important, and if we are correct concerning their relationship to changes in physical symptoms, then they are very probably related to the estrogen replacement and reflect positive effects from it.

Discussion

In retrospect, there are several changes in our program that possibly would have revealed more of the answers for which we were searching. Among these are matters of experimental technique, measuring instrument, timing and population. There is a good possibility that more changes would have been detected utilizing a larger group of women that had reached or were going into their natural climacteric than in our group of predominately surgical patients.

We feel that our project did open some new areas that should be investigated. When more of these areas are fully explored, the physician should be more effective in his treatment of the whole woman. We feel the entire symptom complex of the menopausal storm should be treated, not just the vaginal cytology. The physician must become more aware of the subtle, and sometimes not so subtle, psychological and physical changes that occur in his patient.

Table III

t test of the Significance of the Difference Between the Scores of the Patients Who Dropped From the Study and Those Who Remained

	Pa	Pt	Sc
t	1.82 ($<.05$)	1.51 ($<.10$)	2.31 ($<.025$)

It is quite likely that in the future we will be able to determine not only the hormonal deficit in advance of treatment but also predict with a greater degree of accuracy the psychological as well as physiological response. When this becomes practical, doctor-patient relations will become more harmonious with consequently greater possibilities of successful therapy.

Estrogen replacement therapy may not be the panacea once projected for it, but there is little doubt of its value in helping the majority of menopausal women to become compatible women.

References

1. Estrogen Therapy for Postmenopausal Females. Robert B. Greenblatt, The New Eng. Journal of Medicine, 272:305-308, Feb. 11, 1965.

2. The Menopausal Woman and Sex Hormones. Herbert S. Kupperman, Medical Aspects of Human Sexuality 1:64-68, Sept. 1967.

3. Administration of Estrogens To Older Women, A Psychometric Evaluation. Herman I. Kantor, Am. Journ. Ob. Gyn. 101:658-661, July 1, 1968.

4. Weight Loss and Psychological Observation of Gynecological Patients. O. T. Bolding and H. C. Willcutt, The Ala. Journ. of Med. Sciences 5:158-163, April 1968.

5. Limited Relationship of Maturation Index to Estrogen Therapy for Menopausal Symptoms. Sherwin A. Kaufman, Ob. Gyn. 30:399-407, Sept. 1967.

6. The Climacteric: Its Role in Aging. Alvin F. Goldfarb, Medical Science 48-52, February 1967.

7. Contemporary Therapy of the Menopausal Syndrome. H. S. Kupperman, et al., J. A. M. A. 171:1627-1637, Nov. 21, 1959.

Books of Interest To Doctors And Patients

THE MECHANISM OF MIND, by Edward de Bono, Simon and Schuster, 630 5th Avenue, New York, illustrated with diagrams by the author, 275 pages—$5.75.

There are those who suppose that the brain will forever remain a mystery. There are those who suppose that one day the way the brain works will be revealed in all its detail. Of what use would such knowledge be? Would the problems of mankind be suddenly solved by a surge of understanding? Would one be able to make practical use of the knowledge?

The author asks the questions at the beginning, then suggests that "It may be that the brain is not too difficult to understand . . . but too easy."

From there he proceeds to picture what he believes the brain to be—a sort of receptive plate that takes facts and fancies onto its memory surface, wherever they happen to fall, and from there we develop our thinking. "Ideas must advance," he says, and "if they miss the right direction they move further and further in the wrong direction . . . The brain does not seek to understand and explain but to create explanations--and that is a very different thing. The explanations may be highly acceptable without having much relevance to what is being explained. Can one escape from the circular self-satisfaction of elaborate philosophical description?"

The author will be remembered for his brilliant, widely hailed first book, *New Think*, which the San Francisco Examiner hailed as "a fresh breath of air through the sealed rooms of the computer age," and New York Magazine as "A delight. Its ultimate rationality, clarity and playfulness are evident throughout. One of those rare books which make the reader—and the reviewer —act out its premises."

The Mechanism of Mind cannot be treated with indifference.

—W. J. Mahoney, Jr.

The Latest Concepts In Surgical Management of Peptic Ulcer Disease

By

Frank G. Moody, M. D.

Treatment of peptic ulcer disease is based upon the simple, empiric observation that peptic ulcer does not occur in the absence of gastric acid. It is well known that gastric acidity cannot always be effectively controlled by medical means alone. The following is a review of the current status and rationale for the surgical management of this problem. This is a fortunate time for such a discussion, since operative therapy has evolved into a safe and effective means for controlling the advanced manifestations of this disease.

Objectives Of Surgical Therapy For Duodenal Ulcer

Operative therapy for duodenal ulcer is usually reserved for those patients who develop complications or incapacitating symptoms of their disease. Approximately 15 per cent of patients with duodenal ulcer ultimately fall into this category. Definitive operations for duodenal ulcer, regardless of the nature of the complication requiring surgery, must not only salvage life but also provide permanent relief from ulcer symptoms. Clinical experience has shown that reduction in acid secretion is an essential feature for successful surgical therapy in this regard. For example, the failure of simple gastroenterostomy as an effective means for controlling duodenal ulcer was related to the fact that it did not provide sufficient reduction in acid secretion. Gastric resection, therefore, gradually evolved as an effective way to reduce the rate of acid secretion and ulcer recurrence but at the price of increased operative mortality and postoperative morbidity. More recently, an intensive effort has been made to identify the ideal balance between operative safety and assurance against recurrent ulcer disease. Vagotomy has been generally accepted as the primary surgical modality for reducing acid secretion. Controversy still exists as to whether vagotomy must be coupled with removal of the gastric antrum to insure reasonable protection against recurrence, or whether, in fact, vagotomy accompanied by gastric drainage is sufficient in this regard.[1-3] There can be no doubt but what a finite recurrence rate in the range of 5-20 per cent accompanies this latter procedure, while the addition of distal gastrectomy to vagotomy provides nearly maximum protection against subsequent ulcer disease.[4] As regards the question of who should have operative therapy, I share Priestley's[5] concept that indications for surgery must be individualized. I will try to support my own preference for early intervention in the disease by emphasizing the relative safety and effectiveness of surgical therapy.

Risk of Surgical Therapy For Duodenal Ulcer

The fact that elective operations for peptic ulcer can be accomplished with negligible

Dr. Moody is Associate Professor of Surgery, Chief, Division of Gastrointestinal and General Surgery, The University of Alabama Medical College, Birmingham, Alabama.

Presented at the 22nd Clinical Convention of the American Medical Association, Miami Beach, December 3, 1968.

mortality has been well documented at the University Hospital of the University of Alabama Medical Center, where there were no deaths following 137 consecutive elective operations for duodenal ulcer during the five year period 1963 through 1967. It should be noted with pride in our system for training surgeons that 60 per cent of these operations were performed by the resident staff under faculty supervision. This experience, furthermore, points out that age itself should not preclude operative therapy when indications for surgery exist, since 20 per cent of the patients in this series were over the age of 70. It can be concluded from this study that elective surgery for peptic ulcer can be accomplished with a negligible mortality when performed by well trained surgeons.

This is not the case, however, when massive hemorrhage requires an emergency operative procedure. There were 13 postoperative deaths in 88 consecutive patients operated upon for this complication during a comparable period at the University Hospital. Determinants of mortality under these conditions appear related, for the most part, to age, associated illness, the systemic effects of massive hemorrhage and transfusion, and the technical problem of dealing with the ulcer site. Eleven of these operative deaths followed resection of the stomach. More recently we have employed pyloroplasty and vagotomy with deep ligature of the bleeding point within the ulcer crater as the simplest and quickest way to control hemorrhage in such patients. Bleeding was controlled in this way in six consecutive cases in the present series with only one death in an 88 year old female from a heart attack on the eighth postoperative day. The question of whether vagotomy and pyloroplasty will afford long-term protection from recurrent ulcer disease seems of secondary importance when confronted with this serious complication. There has been much discussion about early recurrent hemorrhage following this procedure, but the incidence of rebleeding appears to be quite low in the hands of those who perform this operation with great precision and care.[6] In my opinion, the increased chance for survival employing pyloroplasty, vagotomy and ligature far outweighs the risk of recurrent disease and should be employed in the majority of cases when massive hemorrhage requires emergency surgery. This is especially true for the older age group and for those patients who have a serious associated illness.

If distal gastrectomy with vagotomy provides maximum protection against recurrent ulcer, why then can't it be employed safely in the patient with massive hemorrhage? The answer to this question resides in the fact that patients with acute hemorrhage often have an ulcer deeply penetrating into the posterior aspect of the duodenum. It is, in fact, this location of the ulcer which leads to massive hemorrhage. Resection of the stomach in this instance requires transection of the duodenum through an area of scar and inflammation. Subsequent healing of the cut end of the duodenum is compromised by the presence of bile and pancreatic juice in this unfavorable environment. In fact, the two and only deaths which occurred in our hospital in 1967 for chronic duodenal ulcer disease were related to the tragic complication of a "blown" duodenal stump following hemigastrectomy and vagotomy. There is good reason to believe that these two patients would be alive today if a lesser procedure not involving resection of the lower end of the stomach and proximal duodenum had been employed to control their massive hemorrhage.

Elective Operations

There are those who believe that pyloroplasty and vagotomy is, in fact, an ideal operation for all the complications of peptic ulcer disease.[1] While I am enthusiastic for this approach in the patient with massive hemorrhage who requires emergency surgery, I reserve its use for rather specific indications in the ulcer patient who is to undergo elective operation. In this latter patient, I am most concerned with permanent cure,

which clearly can best be accomplished by antrectomy and vagotomy.[4] The patient who comes to operation for intractable pain is an ideal candidate for this approach. It is equally well suited for the patient with recurrent episodes of bleeding when operated upon electively, since a favorable site for transecting the duodenum is usually encountered. I never hesitate, however, to employ vagotomy and drainage when I anticipate a difficult duodenal dissection. The risk of recurrence in this situation is much preferred to a life-threatening post-operative complication which may accompany resection.

A prime consideration in this operative approach is removal of the gastric antrum which is known to be the major source of gastrin in man. This can be accomplished by actual mapping of the non-secretory area of the lower portion of the stomach with pH sensitive paper.[7] In practice, however, it is fairly well accepted that the antrum will be encompassed in the majority of cases when the lower half of the stomach has been removed. I prefer to reestablish gastrointestinal continuity by joining the gastric remnant to the duodenum as a gastroduodenostomy whenever possible, thereby avoiding the complications which may follow a gastrojejunostomy, such as tortion, internal hernia, afferent loop syndrome, and a host of other rare but distressing sequelae.

Gastric drainage and vagotomy is an ideal elective procedure in cases with advanced age or severe associated illness since it provides adequate protection against recurrence under these circumstances. It is also a desirable operation for long-standing chronic obstruction when this complication is accompanied by marked debility. Pyloroplasty and vagotomy has evolved as a safe, definitive approach to the patient who manifests an acute perforation following long-standing ulcer disease.[8] Several groups have demonstrated that resectional surgery can also be accomplished with a low mortality rate in this population.[9,10] Simple plication, however, should be employed when perforation is the sole manifestation of ulcer disease, since it is known from experience that this patient may have no further ulcer symptoms following recovery. This procedure is also desirable when surgical therapy of a perforated ulcer has been delayed beyond several hours.

The side effects or late sequelae of gastric surgery such as dumping, small capacity syndrome, weight loss, anemia, and osteoporosis have all been well documented. It is generally agreed that post-gastrectomy symptoms are directly related in their severity to the amount of stomach removed. Consequently, most surgeons now avoid extensive resections for duodenal ulcer disease. Pyloroplasty and vagotomy is also accompanied, however, by unpleasant side effects which are less frequent and severe than those which accompany gastric resection. In fact, the extragastric effects of vagotomy are not yet fully known. Selective vagotomy wherein only the vagus innervation of the stomach is interrupted has been advocated in order to avoid diarrhea, the most prominent symptom of truncal vagotomy.[11] While this procedure is attractive in theory, it has not gained widespread acceptance since truncal vagotomy is a less complicated operation. Advocates of selective vagotomy emphasize that this is the best way to insure vagal denervation of the stomach, and possibly this consideration will represent the greatest advantage of this approach.[12]

Surgical Therapy Of Gastric Ulcer

The surgical treatment of gastric ulcer deserves special consideration since it appears to be a different disease than duodenal ulcer. While massive hemorrhage, obstruction, and even perforation may complicate a gastric ulcer, these are less frequent than the symptoms of abdominal pain or disturbances in nutrition. A further consideration is the possibility that gastric ulcer may be a manifestation of carcinoma. The latter has assumed less importance as an indication for surgery with improved methods of radiologic, endoscopic and cytologic diagnosis. The pri-

mary indication for operative treatment of gastric ulcer at the present time is failure to heal on medical therapy. The most popular form of operative therapy consists of removing the ulcer and that portion of the stomach within which it resides. This approach can be carried out simply and safely in the majority of patients since the most common site for this lesion is in the distal third of the stomach. There is evidence that a gastric ulcer will heal when the acid secretory capacity is reduced by vagotomy and pyloroplasty.[13] Multiple biopsies of the ulcer are taken in order to eliminate the possibility of cancer. I reserve this approach, however, for those patients who present with high lying gastric ulcers which are technically difficult to remove by limited resection of the stomach.

Multiple superficial gastric erosions represent an unresolved therapeutic challenge. This disease often occurs in a setting of massive physical or thermal trauma, overwhelming infection, or extensive operative stress. While vagotomy and pyloroplasty has been employed successfully in a few such cases in our hospital, the incidence of rebleeding and ultimate mortality is high. Extensive gastric resection in such patients is also associated with a high mortality and failure rate. If at operation we can identify a single erosion which has penetrated a large vessel, then we prefer to excise that erosion and perform a pyloroplasty and vagotomy. When erosions involve the distal half of the stomach, then a partial gastrectomy with vagotomy is considered to be the preferred operation. Diffuse erosive gastritis of the proximal stomach remains a surgical enigma. I believe that it is best to do a vagotomy and pyloroplasty in this disease and make an attempt to suture the predominant areas of bleeding. It is generally conceded that we do not as yet have an adequate surgical approach to this entity. We presently strive for early identification of patients who might develop this syndrome and treat them vigorously with antacid therapy either orally or through an indwelling nasogastric tube.

When gastric ulcer is found in association with duodenal ulcer disease, it is essential to employ the principles of duodenal ulcer surgery if an operative approach is required. It is well established that recurrence after distal gastrectomy for gastric ulcer is rare except when there is a history or evidence of chronic duodenal ulcer. Furthermore, an ulcer which occurs within the pyloric antrum, while gastric in location, has the physiologic features of a duodenal ulcer and should be treated as such. My own preference is to advise surgery fairly early in the course of this form of ulcer disease if prompt control is not gained by medical management.

Other Considerations

An ideal ulcer operation which will insure freedom from recurrence without risk or nutritional disturbance has not as yet been identified. Selective surgery, whereby the extent of operation for duodenal ulcer is proportional to the patient's acid secretory capacity, may provide a means for a more quantitative approach to this problem. The results of those who employ selective gastric surgery, however, are not appreciably better than those obtained by the more traditional approach outlined above.[14-17] This may be related in part to an inability to assess in a meaningful way the factors which lead to peptic ulcer. In my opinion, the main value of gastric analysis lies in its ability to identify achlorhydria or hypersecretory states. I have found the one hour basal and maximal histamine test of Kay[18] to be simple and reliable in this regard. It is especially important to identify patients with the Zollinger-Ellison syndrome, since to overlook such individuals can lead to a disastrous surgical result if total gastrectomy is not performed.

There are many facets to the surgical treatment of peptic ulcer disease. I have attempted to relate a simple and safe clinical approach which is in step with the times. In my opinion, the priorities for selection of

an operation for peptic ulcer are, in order—safety, effectiveness, and the absence of unpleasant side effects. It would seem that future progress will depend on developing better ways for matching the procedure to the patient. As in all areas of clinical medicine, the ultimate solution resides in a complete understanding of the disease, a reality which at this point in time appears to be in the very distant future. It is comforting to know, however, that the recalcitrant ulcer can be managed safely by operative means with a remarkably low recurrence rate or serious sequelae within the framework of our present surgical expertise.

References

1. Schofield, Philip F., Watson-Williams, E. J., and Sorrell, V. F.: Vagotomy and Pyloric Drainage for Chronic Duodenal Ulcer. Long-Term Results, Arch Surg 95:615, 1967.

2. Herrington, J. Lynwood, Jr.: Vagotomy-Pyloroplasty for Duodenal Ulcer: A Critical Appraisal of Early Results, Surgery 61:698, 1967.

3. Bryant, W. Michael, Klein, David, and Griffen, Ward O., Jr.: The Role of Vagotomy in Duodenal Ulcer Surgery, Surgery 61:864, 1967.

4. Scott, H. William, Jr., Sawyers, John L., Gobbel, Walter G., Jr., Herrington, J. Lynwood, Jr., Edwards, William H., and Edwards, Leonard W.: Vagotomy and Antrectomy in Surgical Treatment of Duodenal Ulcer Disease, Surg Clin N Amer 46:349, 1966.

5. Priestley, James T.: Thoughts regarding the Patient with Chronic Duodenal Ulcer, Surg Clin N Amer 47:841, 1967.

6. Farris, Jack Matthews, and Smith, Gordon Knight: Appraisal of the Long-Term Results of Vagotomy and Pyloroplasty in 100 Patients with Bleeding Duodenal Ulcer, Ann Surg 166:630, 1967.

7. Bergstrom, H., and Broome, A.: Preoperative Determination of the Boundary Between the Gastric Antrum and Fundus, Acta Chir Scandinav 128:526, 1964.

8. Hinshaw, David B., Pierandozzi, John S., Thompson, Ralph J., Jr., and Carter, Richard: Vagotomy and Pyloroplasty for Perforated Duodenal Ulcer. Observations on 180 Cases, Am J Surg 115:173, 1968.

9. Jordan, George L., Jr., DeBakey, Michael E., and Cooley, Denton A.: The Role of Resective Therapy in the Management of Acute Gastroduodenal Perforation, Am J Surg 105:396, 1963.

10. Maynard, Aubre de L., Froix, Cleo J. L., and Oropeza, German: Gastroduodenal Perforation with Conclusions on the Role of Definitive Surgery, Arch Surg 97:96, 1968.

11. Harkins, Henry N., Stavney, L. Stanton, Griffith, Charles A., Savage, Lawrence E., Kato, Tetsuo, and Nyhus, Lloyd M.: Selective Gastric Vagotomy, Ann Surg 158:448, 1963.

12. Sawyers, John L., Scott, H. William, Jr., Edwards, William H., Shull, Harrison J., and Law, David H., IV: Comparative Studies of the Clinical Effects of Truncal and Selective Gastric Vagotomy, Am J Surg 115:165, 1968.

13. Farris, Jack Matthews, and Smith, Gordon Knight: Treatment of Gastric Ulcer (in situ) by Vagotomy and Pyloroplasty: A Clinical Study, Ann Surg 158:461, 1963.

14. Bruce, John, Card, W. I., Marks, I. N., and Sircus, W.: The Rationale of Selective Surgery in the Treatment of Duodenal Ulcer, J Roy Coll Surg Edinb 4:85, 1959.

15. Orr, Ian M.: Selective Surgery for Peptic Ulcer: A Review, GUT 3:97, 1962.

16. Broome, A., and Bergstrom, H.: Selective Surgery for Duodenal Ulcer Based on Preoperative Acid Production, Acta Chir Scandinav 132: 170, 1966.

17. Myren, J., Gjeruldsen, S., and Fretheim, B.: Gastric Secretion Before and After Graded Partial Gastrectomy for Duodenal Ulcer, Scandinav J Gastroent 1:132, 1966.

18. Kay, Andrew W.: Effect of Large Doses of Histamine on Gastric Secretion of Hcl. An Augmented Histamine Test, Brit Med J 2:77, 1953.



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

NOW IS THE TIME... TO GIVE HER TIME WITH OVULEN-21®

Each tablet contains ethynadiol diacetate 1 mg., mestranol 0.1 mg.



The new mother needs time . . .
to adjust to motherhood,
to give her new baby all the love
and attention he requires.
She needs time for her husband . . .
and for herself as well . . .
so that she can come to terms
with the increased cares
and responsibilities now facing her.
She needs time to decide
when she will have additional children
and how many she will have.

OVULEN-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

GIVES HER TIME

Your prescription for Ovulen-21 gives the new mother time to meet her family's present needs...to plan for her family's future.

She can take Ovulen-21 confidently and comfortably month after month. Its dependability is enhanced by its simplicity of use. A woman needs little or no time to learn the simple Ovulen-21 regimen: three weeks on—one week off. And the automatic record-keeping of the petite, virtually "patient-proof" Ovulen-21 Compack® helps to maintain her schedule...helps put time on her side.

Immediately post partum is the time

It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

It is also the most opportune time, since she is conveniently present in the hospital, for her to be given both instructions and a prescription.

Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebravascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thrombaembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	*Mortality Rates*		*Hospitalization Rates (Morbidity)*
	Age 20-34	*Age 35-44*	*Age 20-44*
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: amenorrhea after treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching. The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.



References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see complete prescribing information.

Where "The Pill" Began

G. D. SEARLE & CO., P.O. Box 5110, Chicago, Ill. 60680 SEARLE

SO 8-5117 B

972

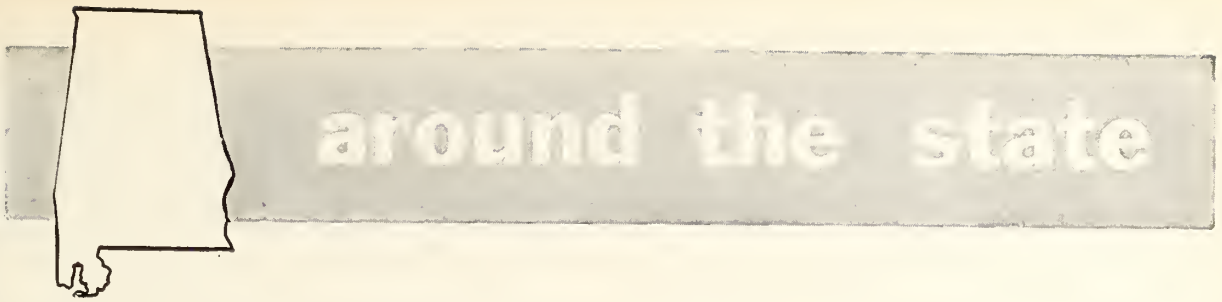
What's Polycillin® (ampicillin trihydrate) got to do with the price of bananas?

Just this: According to the U.S. Bureau of Labor Statistics, bananas are one of the few things that actually cost less today than five years ago. The same is true of Polycillin. In fact, the price of Polycillin has been reduced about 30% since its introduction in 1963...making it, according to national surveys of patient costs, as economical as leading brands of tetracycline and erythromycin.

And Polycillin is available in a variety of dosage forms for your patients—more than any other ampicillin. It comes in 250 mg. and 500 mg. capsules; in convenient, chewable tablets of 125 mg; oral suspension, 125 mg. and 250 mg. per 5 ml.; and in pediatric drops, 100 mg. per ml. Also available parenterally as Polycillin-N (sodium ampicillin).

BRISTOL
BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201





Vital Statistics

NEW MEMBERS

Jefferson County

Arias, Manuel, b 35, mc National University of Bogota 60, limited lic 69, 1919 South Seventh Avenue, Department of Radiology, Birmingham, Alabama 35233 R. Phone 934-5131

Becker, Folke, b 07, mc Temple 36, recip NBME 65, 1527 - 9th Avenue South, Birmingham, Alabama 35205 PM 324-1420

Bennett, Austen LeGrande III, b 32, mc Alabama 56, sb 57, 1318 South 19th Street, Birmingham, Alabama 35205 ThS 324-2461 (Transfer from Non-member Tuscaloosa County)

Blythe, John Coley, b 39, bc Alabama 67, sb 69, 120 Morris Boulevard, Birmingham, Alabama 35209 (Resident) 871-5425

Brosch, Frederick R., b 33, mc University of Vienna 60, limited lic 69, 1919 South Seventh Avenue, Birmingham, Alabama 35233 Anes. 934-4678

Han, Sang Yeung, b 28, mc Chonnam University 55, limited lic 68, 619 South 19th Street, Birmingham, Alabama 35233 R 934-5131

Harman, Maureen Alice, b 39, mc Seton Hall, New Jersey 63, recip NBME 68, 1919 South Seventh Avenue, Birmingham, Alabama 35233 I 934-5186

Langley, John Olin, b 34, mc Alabama 65, sb 66, 1919 South Seventh Avenue, Birmingham, Alabama 35233 Ob-Gyn 934-4011

McRae, John Finley, Jr., b 34, mc Tulane 61, recip La. 68, 1919 South Seventh Avenue, Birmingham, Alabama 35233 NS 934-4698

Pruet, Charles Wilburn, b 36, mc Alabama 62, sb 63, 924 South 18th Street, Birmingham, Alabama 35205 ALR 322-8705

Rackley, Charles Edward, b 33, mc Duke 58, recip North Carolina 68, 1919 South Seventh Avenue, Birmingham 35233 I-C 934-5378

Rubin, Richard Bennett, b 37, mc Alabama 66, sb 69, 1919 Seventh Avenue South, Birmingham, Alabama 35233 P 934-5151

Vietk, Jiri Jakub, b 35, mc Faculty of General Medicine Charles University 59, limited lic 69, 1919 South Seventh Avenue, Birmingham, Alabama 35233 N 934-5131

Yeargan, Wilfred Ward, b 40, mc Alabama 65, recip Georgia 66, 1711 Ninth Avenue South, Birmingham, Alabama 35205 Oph 322-4575

Madison County

Basore, John William III, b 38, mc Alabama 65, sb 66, 930 Franklin Street, Huntsville, Alabama 35801 GP

Reskof, David Allen, b 34, mc Pittsburg 60, recip Penn. 69, 401 Lowell Drive, Huntsville, Alabama 35801 P

Smith, Almoth Horton, b 37, mc Tulane 61, recip. La. 65, 401 Lowell Drive S. E., Huntsville, Alabama 35801 Ob.

DEATHS

Baldwin County

Jordan, Henry Claudius, Fairhope, Alabama —Deceased August 4, 1969

Jefferson County

Roberts, Wyatt Sanford, Birmingham, Alabama—Deceased August 13, 1969

Russell County

Nix, Alton Roscoe, Phenix City—Deceased September 20, 1969

CHANGES OF ADDRESS OF MEMBERS

Choctaw County

Gully, Virgil Samuel, present Butler to 4125 Hillsboro Drive, Tuscaloosa, Alabama 35401

Colbert County

Carmichael, Archie Hill, Jr., present Sheffield to 907 Woodward Avenue, Muscle Shoals, Alabama 35660

William, Roy Winston, present Sheffield to 907 Woodward Avenue, Muscle Shoals, Alabama 35660

Dallas County

Ross, Carlos James, present Selma to P. O. Box 557, Selma, Alabama 36701

Jefferson County

Edwards, William Sterling III, present Birmingham to 717 Wagontrain Drive S. E., Albuquerque, New Mexico 87112

Foster, Mary Eleanor Olsen, present Birmingham to 25084 Tulip Avenue, Loma Linda, California 92354

Ingle, Leo Ray Jr., present Bessemer to 79 Thrasher Street, New Orleans, Louisiana 70124

Mathis, James William, present Birmingham to 1213 Dellwood Drive, Valdosta, Georgia 31601

McCraw, Edward Fishburne, present Birmingham to Lloyd Noland Hospital, Fairfield, Alabama 35064

Ryan, Robert Thomas, Jr., present Birmingham to 1817 Cedarwood Road, Birmingham, Alabama 35205

Samuels, Joseph Wilburn, Jr., present Birmingham to 943 Sixth Street West, Birmingham, Alabama 35204

Sox, Joe Howle, present Birmingham to 1349 41st Street West, Birmingham, Alabama 35228

Upchurch, James Conway, present Birmingham to 320 Tuscaloosa Avenue, Birmingham, Alabama 35211

West, Otus Theron, present Birmingham to 909 South 15th Street, Suite J, Birmingham, Alabama 35205

Windsor, James Lowery, present Bessemer to 1717 Fourth Avenue North, Bessemer, Alabama 35020

Lauderdale County

Hightower, Russell Garnett, present Florence to P. O. Box 798, Florence, Alabama 35630

Jackson, Alva A., present Florence to 419 North Walnut Street, Florence, Alabama 35630

(Continued on Page 477)

Page 1

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION
(Act of October 23, 1962; Section 4369, Title 39, United States Code)

Publisher: File two copies of this form with your postmaster. Form Approved Budget Bureau No. 46-R029

1. DATE OF FILING: October 1, 1969
2. TITLE OF PUBLICATION: THE JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA
3. FREQUENCY OF ISSUE: Monthly
4. LOCATION OF KNOWN OFFICE OF PUBLICATION: 19 South Jackson Street, Montgomery — Montgomery, Alabama 36104
5. LOCATION OF THE HEADQUARTERS OR GENERAL BUSINESS OFFICES OF THE PUBLISHERS: 19 South Jackson Street, Montgomery, Alabama 36104
6. NAMES AND ADDRESSES OF PUBLISHER, EDITOR, AND MANAGING EDITOR
PUBLISHER: Medical Association of the State of Alabama, Montgomery, Alabama
EDITOR: William L. Smith, M. D., 19 South Jackson Street, Montgomery, Alabama 36104
MANAGING EDITOR: L. P. Patterson, 19 South Jackson Street, Montgomery, Alabama 36104
7. OWNER

NAME	ADDRESS
Non-Profit Organization Medical Association of the State of Alabama	19 South Jackson Street, Montgomery, Ala.

8. KNOWN BONDHOLDERS, MORTGAGEES, AND OTHER SECURITY HOLDERS OWNING OR HOLDING 1 PERCENT OR MORE OF TOTAL AMOUNT OF BONDS, MORTGAGES OR OTHER SECURITIES

NAME	ADDRESS
None	

9. FOR COMPLETION BY NONPROFIT ORGANIZATIONS AUTHORIZED TO MAIL AT SPECIAL RATES (Section 132.122, Postal Manual)
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes: ☐ Have not changed during preceding 12 months ☐ Have changed during preceding 12 months (If changed, publisher must submit explanation of change with this statement)

10. EXTENT AND NATURE OF CIRCULATION	AVERAGE NO. COPIES EACH ISSUE DURING PRECEDING 12 MONTHS	ACTUAL NUMBER OF COPIES OF SINGLE ISSUE PUBLISHED NEAREST TO FILING DATE
A. TOTAL NO. COPIES PRINTED (Net Press Run)	2850	2,900
B. PAID CIRCULATION: 1. SALES THROUGH DEALERS AND CARRIERS, STREET VENDORS AND COUNTER SALES	None	None
2. MAIL SUBSCRIPTIONS	2,643	2,653
C. TOTAL PAID CIRCULATION	2,643	2,653
D. FREE DISTRIBUTION (including samples) BY MAIL, CARRIER OR OTHER MEANS	197	196
E. TOTAL DISTRIBUTION (Sum of C and D)	2,840	2,849
F. OFFICE USE, LEFT OVER, UNACCOUNTED, SPOILED AFTER PRINTING	10	51
G. TOTAL (Sum of E, F—should equal net press run shown in A)	2,850	2,900

I certify that the statements made by me above are correct and complete. (Signature of editor, publisher, business manager or owner)
Mng. Editor L. P. Patterson

POD Form 3526 May 1968

One of these disposables comes prefilled.
Its unit dose – in nonreactive glass cartridge – is premeasured.
The cartridge is clearly labeled:
drug name, strength, control number.
Even expiration date where appropriate.

You're more confident that the patient gets...





. . . just what the doctor ordered with the Tubex Closed Injection System.

Injections with the Tubex system are as easy as 1, 2, 3,

1. Select—from an extensive variety of prefilled Tubex sterile cartridge-needle units.* No multi-dose vials to bother with; no unlabeled syringes to cause confusion.

2. Inject—with a minimum of pain. Thanks to the single-use, stainless-steel needle that's both ultra-sharpened and siliconized. Aspirate simply and conveniently.

3. Throw away—empty cartridge-needle unit. Never used again, it can't transmit infection. And there's no clean-up job.

*For injectables not yet in the ever-expanding prefilled Tubex line, empty sterile cartridge-needle units are available.

TUBEX®

Closed Injection System
Hypodermic Syringe
Sterile Cartridge-Needle Unit

Wyeth® UD UNIT DOSE MEDICATION™

Wyeth Laboratories Philadelphia, Pa.

(Continued from Page 474)

Lee County

Carter, A. Z., Jr., present Auburn to P. O. Box 2208, Auburn, Alabama 36830

Macon County

Kenney, Howard Washington, present Tuskegee Institute, to Regional Medical Director, Region 1, Veterans Administ., Washington, D. C.

Madison County

Denton, Robert Officer, present Huntsville to 201 Longwood Drive S. E., Huntsville, Alabama 35801

Mobile County

Thames, Arnold Frederick, present Mobile to 4009 Old Shell Road, Apt. 9-E, Mobile, Alabama 36608

Weldon, Joseph Marion, present Mobile to 446 Old Line Avenue, Maryland City, Laurel, Maryland 20810

Monroe County

Curtright, William Henry Jr., present Monroeville to 1919 South Seventh Avenue, Birmingham, Alabama 35233

Montgomery County

Garrick, Jean Present Montgomery to 2105 East South Boulevard, Montgomery, Alabama 36111

Smith, Walton Harold Young, present Montgomery to 3104 South Hull Street, Montgomery, Alabama 36105

Morgan County

Naylor, Lionel Z., present Decatur to P. O. Box 2211, Decatur, Alabama 35601

Russell County

Corder, Vernon Woodard, present Phenix City to 573 West Peachtree Street N. E., Atlanta, Georgia 30308

Walker County

Olsen, Frank Bernard, present Jasper to 504 Ridge Road, Jasper, Alabama 35501

CHANGE OF ADDRESS OF NONMEMBERS

Russell County

Barraza, Lionel Gennaro, present Phenix City to Louisiana

MEMBERS TRANSFERRED

Jackson County

Murphree, Roland E., 915 So. Broad Street, Scottsboro, Alabama from member Blount County

Russell County

Beck, Ronald Vance, from Jefferson County to 2000 18th Street, Phenix City, Alabama 36867 ObG

CHANGE OF SPECIALTIES

Etowah County

Frantz, William E., 101 South 12th Street, Gadsden, Alabama 35901, Psychiatry

NEW TELEPHONE NUMBERS

Anderson, J. B., Jr.	332-4770
Carmichael, A. H.	383-5524
Henderson, R. J.	872-6219

" . . . For Thy Stomach's Sake"

Present-day knowledge tends to support the claim of Louis Pasteur that "Wine is the most healthful and most hygenic of all beverages," according to a brochure recently released titled "Wine and Health". Typical chapter headings are: "Wine and Tension," "Wine in Special Diets," "Wine in Hospitals," "Wine, Gout and Cirrhosis," and "Excessive Drinking." The booklet is published by Pacific Coast Publishers, Menlo Park, California.

Storm Veteran, MASA Ex-Prexy, In Next Year's 50-Year Club

When Camille struck Mississippi's Gulfport with all the fury in its quiver of deadliness, a past President of the Medical Association of the State of Alabama was right there to share in whatever happened to his younger daughter, Peggy; her husband, Clint Hamilton; their three daughters and two sons.



Dr. Daves

The physician in the case is Dr. James Gordon Daves of Cullman, who next spring at the annual meeting of MASA in Mobile will share with nine other Alabama Doctors the distinction of brand-new membership in MASA's 50-Year Club. This means that each of the ten received his M. D. degree in 1920.

Born on Tuesday, Nov. 24, 1891, in the "Free State of Winston," Ala., James G. Daves spent his childhood on the farm, graduating from Winston County High School, going on to the University of Tennessee for his pre-med studies, and earning his M. D. degree from Emory in 1920.

Mrs. Daves is the former Louise James, the daughter of a doctor, and they have one other living child, Miss Marise Daves, currently on the staff of the University of Illinois. They lost their only son, James Gordon Daves, Jr., in 1944 at the age of 25.

Travel is the expensive hobby to which Dr. Daves confesses, and he and Mrs. Daves have visited in Alaska and Mexico, in Italy and Holland, Denmark, France and England, but as this can be only an occasional indulgence, he does consistently more traveling around his lawn, pushing a mower or pulling a rake.

If the end of half a century in the practice of medicine may be considered a "graduation," then the year 1970 salutes the largest 50-year class in recent history, with ten scheduled for recognition in the pages of the Journal of the Medical Association of the State of Alabama in the months ahead of the annual meeting. The other nine, about whom you will be reading, are, in alphabetical order:

Herbert B. Dowling, M. D., Mobile; William Edward McGrath, M. D., Sheffield; James Leslie Taylor, M. D., Mobile; William Getz Thuss, M. D., Birmingham; Henry Otis Walker, M. D., Huntsville; Maurice S. Whiteside, M. D., Cullman; Frank C. Wilson, M. D., Birmingham; Gerald G. Woodruff, Sr., M. D., Anniston; and Lewis G. Woodson, Jr., M.D., Birmingham.

And just to induce these ten to feel youthful by comparison with their elders, there are five Alabamians who, having been ten years members of the 50-Year Club, could now boast membership in the 60-year club, if there were such a thing:

They are: William J. Blount, M. D., Millry, Washington County; Harris P. Dawson, M. D., Montgomery; Oscar N. Edge, M. D., Troy, Pike County; Hugh Dixon Green, M. D., Decatur; T. Brannon Hubbard, M. D., Montgomery.

Biographical sketches along with pictures of the nine other members of the 50-Year Club should be sent in immediately.

Death is Secondary

For cancer patients, says an essay on psychological considerations, "the greatest threat seems to be not so much that of death, but rather of pain, helplessness, rejection, and progressive isolation."



fast start on a short therapeutic course

Sterazolidin®

50 mg. phenylbutazone
1.25 mg. prednisone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

Prompt anti-inflammatory action for...
relieving pain and stiffness
reducing tenderness and swelling
restoring joint movement
in bursitis, synovitis, tenosynovitis
and acute fibrositis.

Total treatment time: 7 days
Usual dosage: 2 capsules t.i.d.

terazolidin is valuable in the treat-
ent of acute rheumatic conditions so
ften refractory to routine therapy.
owever, it is a potent drug, not a simple analgesic. Therefore, Stera-zolidin should never be administered casually. For complete details on dosage, adverse reactions, contrain-dications and precautions, please see the following two pages.

Sterazolidin®

Each capsule contains:

Butazolidin®, brand of phenylbutazone	**50 mg.**
prednisone	**1.25 mg.**
dried aluminum hydroxide gel	**100 mg.**
magnesium trisilicate	**150 mg.**

Antiarthritic
Anti-inflammatory

Capsules

Important Note Butazolidin, brand of phenylbutazone, and prednisone, the active ingredients of Sterazolidin, are both potent drugs; the pharmacologic action of each should be borne in mind when Sterazolidin is prescribed. Sterazolidin combines anti-inflammatory, analgesic, antipyretic, and antiallergic properties and cannot be considered a simple analgesic and should never be administered casually. The usual warnings, precautions and contraindications associated with Butazolidin, brand of phenylbutazone, therapy and steroids apply to Sterazolidin.

Indications: *Chronic treatment of:* rheumatoid arthritis, rheumatoid spondylitis, osteoarthritis; and also treatment of acute rheumatic conditions such as bursitis, synovitis, tenosynovitis, various forms of acute fibrositis, and acute gouty arthritis.

Contraindications
Usually absolute: active, questionably healed or suspected tuberculosis, herpes simplex ophthalmia, acute psychoses or severe psychoneuroses, history of blood dyscrasia, the frankly senile patient, and active peptic ulcer.

Relative: exanthematous diseases, particularly varicella and fungal diseases (for other viral diseases, the physician must weigh the possible undesirable effects against anticipated clinical improvement), diverticulitis, recovery phase after gastrointestinal surgery, any condition complicated by cardiovascular disease, renal insufficiency, moderate or severe diabetes mellitus, thrombophlebitis, osteoporosis, convulsive disorders, thyroid disease, history of drug allergy, history of peptic ulcer, hypertension, the elderly patient, psychotic tendencies, pregnancy, except in severe disease (the safety of Sterazolidin in pregnancy has not been established), edema, and hepatic damage.

Its use in conjunction with other potent chemotherapeutic agents may greatly increase the possibility of toxic reaction, and this practice is, therefore, inadvisable. Large doses are contraindicated in patients with glaucoma.

Warning Coumarin-type anticoagulants depress prothrombin activity. This is accentuated in some cases when Butazolidin, brand of phenylbutazone, is simultaneously employed in treatment; occasional instances of severe bleeding have been reported. Patients receiving coumarin-type anticoagulants should be very carefully followed for evidence of excessive increase of prothrombin time when Sterazolidin is added to this regimen. Anticoagulant therapy can then be properly adjusted, if necessary. When prescribed alone, Sterazolidin has not been shown to influence prothrombin activity. Persistent or severe dyspepsia may be indicative of peptic ulceration. In these instances, upper gastrointestinal x-ray diagnostic tests should be performed if the drug is continued. Pyrazole compounds, such as phenylbutazone, may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Patients receiving such concomitant therapy, therefore, should be carefully observed for this effect.

Precautions and Adverse Reactions *Gluco-Corticoid Activity:* In some diabetic patients on prednisone, the insulin requirements may be increased. It is advisable to observe diabetic patients carefully during the treatment period. Since gluco-corticoids may unmask latent diabetes, all patients should be observed for this effect.

Electrolytes: Many patients receiving prednisone in average amounts show some loss of sodium, with little or no loss of potassium. With continued high dosage, however, sodium retention and potassium loss have been observed. Butazolidin, brand of phenylbutazone, has a definite tendency to produce sodium retention and hence, edema, particularly in the older age group. Elderly patients or those with hypertension, cardiac defect or renal dysfunction should therefore use Sterazolidin with special caution and the drug should be discontinued if edema develops. Development of edema may be prevented or minimized b withholding salt from the diet. Sodium rete tion may be counteracted with oral diuretic

Nitrogen: With the recommended dosage o Sterazolidin, the possibility of nitrogen loss remote. However, it is recommended that p tients receive adequate protein in their diet Osteoporosis or spontaneous fractures ma occur with prolonged use of prednisone.

Gastrointestinal Tract: Clinical and animal studies do not indicate that the ulcerogenic activity of prednisone or Butazolidin, brand phenylbutazone, is enhanced in the combir tion. To overcome gastrointestinal discomf and occasional eructation in sensitive patie the medication is best taken at mealtime or with milk; Sterazolidin contains antacid cor ponents to minimize the incidence of gastri complaints. All patients should be warned t report immediately the occurrence of black tarry stools. The development of anemia sh immediately suggest gastrointestinal bleed

Blood Elements: Patients receiving prednis exhibit an eosinophil response similar to th seen with other steroids. During the initial weeks of treatment, Butazolidin, brand of phenylbutazone, usually causes some degr of hemodilution and resultant lowering of th red cell count. This phenomenon does not represent a true anemia and is not indicativ of intolerance, but must be distinguished fr true anemia secondary to gastrointestinal bleeding or other causes. With the extensiv use of Butazolidin, brand of phenylbutazone rare cases of agranulocytosis have occurre (ratio less than 1 per 200,000 patients). It should also be noted that agranulocytosis c occur suddenly in spite of regular, repeated normal white counts. Several cases of leukemia and leukemoid reactions have been reported with Butazolidin, brand of phenylbutazone, therapy. Although these reactions cannot be definitely attributed to this drug, t possibility of a causal relationship cannot b excluded. It should also be recognized that arthritic-type pains are sometimes the prese ing symptom of leukemia. Accordingly, all patients receiving Sterazolidin should have

It's aggressive against acute arthritic pain and inflammation.



And, we want you to know all about it

periodic blood counts before and therapy. Any unexpected, significant in the total white count, relative de- in granulocytes, or appearance of ure forms should be regarded as a signal mediate cessation of therapy and institu- appropriate countermeasures. Thrombo- nic purpura and aplastic anemia must considered possible side effects of with Butazolidin, brand of phenyl- ne.

Surgery: Prolonged use of prednisone use a potentially critical degree of cortical insufficiency which may persist fter cessation of prednisone therapy. ore, if a patient is subjected to signifi- ress, such as surgery or trauma, either Sterazolidin therapy or within one year essation of therapy, it is advisable to ster additional steroid and/or ACTH for ration of the stress. Delayed wound g may also occur in patients on pro- therapy.

ons: High or prolonged doses of sone interfere with the usual immune nisms against bacterial and viral infec- nd may promote their dissemination. In l, steroid treatment should not be given presence of infections unless appropri- ibiotic therapy is instituted at the same ystemic and localized infection compli- s during hormone therapy have been ob- , including fulminating pneumonia, ulosis, moniliasis and aspergillosis. intercurrent infection develop, indi- antibiotic therapy must be initiated tly. Every patient who is to receive olidin for any length of time should be ghly examined, including chest x-ray, presence of pulmonary or extrapulmo- berculosis.

nal Imbalance: Gluco-corticoids, in pro- dosage, may cause manifestations of ortisonism or Cushing's syndrome, such onface, abnormal fat deposits, mental ances, muscle weakness and atrophy, ous striae, acne, ecchymoses, hirsutism, ual disturbances, edema, osteoporosis ontaneous fractures, and hypertension. y suppressing adrenocortical function, c prednisone therapy may cause some of atrophy of the adrenal glands. There- Sterazolidin is to be discontinued, the dosage should be tapered off gradu- ally. In addition, it may be advisable to stimulate the adrenal glands with ACTH. Prednisone induces a prompt decrease in the urinary 17-ketosteroids. Pretreatment levels are usually regained within 7 to 14 days after cessation of therapy. Under conditions of long-term administration, a small percentage of patients on phenylbutazone may develop varying degrees of reversible thyroid hyperplasia.

Allergic Response: Development of drug rash should alert the physician to promptly discontinue the drug. The presence of prednisone in Sterazolidin may reduce the degree of allergic response; nevertheless, the same cautious attitude must be preserved with Sterazolidin as with Butazolidin, brand of phenylbutazone, if allergic manifestations occur. Other adverse reactions that have been observed with glucocorticoid therapy include: excessive appetite and weight gain, hyperidrosis, pigmentation, dry,scaly skin, thinning scalp hair, tachycardia, thrombophlebitis, headache, neuropathy (including paresthesias and neuritis), diffuse vasculitis similar to periarteritis nodosa, subcapsular cataracts, impaired renal function, lupus erythematosus-like changes, convulsions, insomnia, abdominal distention, aseptic necrosis of the femoral head, acute pancreatitis and ulcerative esophagitis.

Miscellaneous: Stomatitis and, rarely, salivary gland enlargement occasionally require the interruption of treatment with Butazolidin, brand of phenylbutazone. Adoption of a lower dosage schedule and the institution of strict oral hygiene sometimes prevent recurrence of lesions. The infrequent occurrence of such subjective sensations as vertigo or languor during therapy with Butazolidin, brand of phenylbutazone, is seldom a serious or significant complication. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis and jaundice, hypersensitivity angiitis, pericarditis and several cases of anura and hematuria. Patients should be carefully evaluated before treatment is started and those receiving Sterazolidin must remain under close medical supervision to guard against undesirable reactions such as those described. They should be instructed to report immediately the occurrence of fever, sore throat, lesions in the mouth, or black or tarry stools. It is recommended that periodic examinations of the patient include:

1. Verbal and physical examination, including blood pressure and appraisal of the cardiovascular, digestive and skeletal systems, for indications of toxic reaction.
2. Complete blood count (at weekly intervals during the first month), urinalysis, x-ray and electrolyte studies, as indicated.
3. Check of patient's weight to detect significant water retention.

Dosage Dosage should be individualized. The following general rules should be observed:

In acute therapy, dosage *should not exceed* 12 capsules on the first day and 6 to 8 capsules on succeeding days. Treatment for more than 7 days is rarely necessary. When therapy extends beyond one week, dosage should not exceed 6 capsules a day.

In chronic therapy, dosage *should not exceed* 6 capsules a day and should be tapered off gradually to establish the minimum maintenance level at which the patient still feels reasonably comfortable. A trial period of one week of therapy is considered adequate to determine the therapeutic effect of the drug. In the absence of a favorable response, therapy should be discontinued.

When switching from chronic high steroid therapy to Sterazolidin, the importance of gradual reduction of steroid dosage cannot be overemphasized. It should be kept in mind that the sterold content of 8 capsules of Sterazolidin will replace 10 mg. of prednisone (or its equivalent in related steroids).

Clinical experience indicates that most patients with rheumatoid arthritis may eventually be maintained on 3 to 6 capsules of Sterazolidin a day. It is advisable to administer the total daily requirement in divided doses.

Availabillty Sterazolidin: Light blue and orange capsules, in bottles of 100 and 1000.
(B)46-660-B

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502



Paid With Tokens, Mental Patients Show Improvement

Bryce Hospital personnel, at work on wards where behavior modification techniques have been introduced, are enthusiastic about the dramatic improvements they are seeing there.

Known as token economy programs, the new procedures are now in use on seven wards and involve around 326 patients who are being remotivated towards healthier attitudes and actions. To gain this end, colored plastic tokens are being paid them for improved social interaction and for performing assigned tasks. These include personal grooming, kitchen and ward work.

The tokens may then be spent at a hospital canteen to purchase cigarettes, candy, cosmetics and other items. This cost, however, is a stumbling block to expansion of the program. While it is partially offset by sales of patient-made crafts, much aid is received through donations from church and civic groups, and more is needed.

These provisions help make possible, in the institution setting, simulation of experiences in the outside world, giving patients opportunities to work for what they get. Many are expected to be able to leave the hospital because of the opportunities offered by the program. But even if they cannot leave, patients can enjoy more personal satisfaction.

The therapeutic effects on the patients are reflected in the enthusiastic response of the hospital staff at all levels. Although professional personnel determine much of the treatment process, psychiatric aides are with the patient most of the day, and the system is largely carried out at their level.

Staff shortages also make it plausible for certain patients to participate by helping aides give out the tokens, thereby advancing their own recovery. The tokens are given out all day long, as re-enforcement for improved behavior.

The token economy system has changed some ward environments from custodial to an atmosphere where patients plainly prefer to be up and about. On one ward, where the behavior modification techniques were initiated Jan. 31, the activity level was raised to a significant extent in only a month. A chronic ward where some patients had been hospitalized for 20 years, most were sedentary, spending their days in idleness. Soon ofter the token economy was introduced, many were working on hospital jobs from five to eight hours a day. "It is surprising," said one aide, "to see someone who has not moved from a chair in four years suddenly up sweeping the floor."

On another ward, behavior shaping, resocialization and activity group work is in progress with seriously regressed patients, some of whom are psychotically mute. One, with an impressive vocabulary used only in writing, stunned an aide one day by responding to a question in speech.

"Yes, I would," she said, in reply to a question at the canteen. Institutionalized for almost 25 years, the patient is also resuming an interest in the piano, as a result of the new methods.

Hopes are that in the near future, additional programs can be initiated in the state hospitals. The system is adaptable to many institutions, including teen-age groups. Many variations can be exercised, from small groups to large wards. The focus can center on improving social behavior, grooming, productive activities, leisure-time activities, individual behaviors, group therapy participation, or a combination of any or all of these goals.

In short, almost any kind of ward in the hospital can profit from token economy programs.



introducing an anticostive* antacid

*Avoids constipation.

an antacid formulated especially for the constipation-prone patient

- Gelusil-M has been formulated to help avoid constipation in these patients: hospitalized/bedridden/debilitated/sedentary/pregnant/elderly/on a bland diet/on anticholinergic-antispasmodic drugs/when straining at stool should be avoided.
- Magnesium content helps maintain intestinal fluid volume and motility.
- Some patients may develop loose stools while taking Gelusil-M. This condition is usually dose-related, and usually responds to dose reduction.

introducing new

GELUSIL®-M*

each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate
250 mg. aluminum hydroxide (Warner-Chilcott)
200 mg. magnesium hydroxide

*U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

†Avoids constipation.

See next page for prescribing information ▶

GELUSIL–one name to remember...and a dosage form for every patient.



Gelusil®-M Liquid

especially for the constipation-prone patient

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

the universal take-along antacid

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquid

when constipation is not a problem

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)—or more—between meals and at bedtime, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey
GM-IN-92-4C

Hobbies To Fill A Doctor's Leisure

Big Game Didn't Provide Biggest Danger

The hobby was born years before Arthur Fulton Lincoln dreamed of a profession. As a child he hunted the hills and plains of Nebraska, where his paternal grandfather went as a pioneer a hundred years ago, half a dozen years before the Battle of Little Big Horn, where Custer died.

As an early teenager, when Hitler was becoming restive over the limitations that bound Germany, "Art" was hunting Canadian geese and ducks and envying those who hunted the big game that still roamed the remote reaches of the earth.

Short of his 18th birthday, he entered the University of Nebraska in 1940, entered the Army two years later, and was detached from active duty to complete his education. Enrolling in William and Mary, in Virginia, he played tackle on that school's varsity football team, returning to his native Nebraska for his M. D. degree which he obtained in 1948 from the Medical School, Omaha. Leaving service in 1954, he practiced in Denver for eight years before joining his friend Dr. Paul Lochte in the practice of pathology in Montgomery.

Dr. Lincoln's trophy room, in his home on the corner of Fernway and Allendale Place, holds ample evidence of his hobby. A zebra, a grizzly, and an Arctic wolf supply rugs for the floor, while peering down from the walls are the mounted heads of an African Cape buffalo, a Sable antelope, a huge eland, a roan antelope, a Greater Kudu, an American bison, a caribou, a Russian boar, an Alaskan moose, and a wolverine, among others. In a corner is a pair of elephant tusks from the monster pictured with this article.



The Situtunga (spiral-horn antelope) is one of the rare prizes of a hunting expedition. Because of its ability to submerge to the tip of its nostrils, it must be caught well away from water. This one's head is on the walls of the Lincoln trophy room.

But the Alabama pathologist's narrowest escape had only remotely to do with big-game hunting in Africa and around the world. On a highly successful hunt in Angola, he had as his guide a Portuguese, Rui Alemida, who accepted an invitation to visit him in Mont-Montgomery. Dr. and Mrs. Lincoln took their guest to Dale's Penthouse, atop the towering Walter Bragg Smith Apartments for dinner on that fateful night when fire killed a score of their fellow diners. Driven by the heat, first to the roof and then over the parapet that fenced the area in, the trio clung to a narrow ledge high over the City of Montgomery until they were rescued.

In August of this year, Dr. Lincoln took his only son, 13-year-old Steven, on a big-game hunt to British Columbia, and the boy's



Dr. Lincoln poses with a mammoth rhinoceros he killed in Portuguese Angola.



With his guide and friend, the Portuguese Rui Alemida, Dr. Lincoln poses a bull elephant he killed. This monster weighed almost seven tons. Rui Alemida was with the Lincolns when they escaped the fateful Dale Penthouse fire.

first "bag" included a full grown grizzly, a stone sheep, a mountain goat, and a caribou.

And—who knows?—Steven some day may follow even further in his father's footsteps and qualify for a featured place in another series of the Journal of the Medical Association of the State of Alabama: "Fathers-and-Sons in Medicine."



His father's Hupmobile helps display the results of one day's hunt in Lincoln County, Nebraska, when Dr. Lincoln was still a teenager.

AMA And The Nation's Press

AMA has named a native Philadelphian its director of news media relations. His responsibilities embrace press relations, radio-tv and motion pictures, magazine relations, women's activities, and youth programs.

Announcement of the appointment of Kenneth T. Simendinger to this position was made by Charles S. Lauer, director of AMA's Communications Division. With his baccalaureate from LaSalle and his Masters from Columbia School of Journalism, with newspaper experience in Philadelphia and Washington, Simendinger comes to AMA from the position of public relations director of the General Dynamics Corporation, Washington.

Dulcolax®...so predictable you can almost set patients by it.

Dulcolax works so effectively that the time of bowel evacuation can often be predicted.

Dulcolax tablets taken at night will usually result in a convenient bowel movement the following morning. Dulcolax suppositories generally work within 15 minutes to an hour.

Dulcolax may be given to the aged, pregnant or nursing women, and children. It may be particularly helpful in conditions in which straining should be avoided. The drug, however, is contraindicated in the acute surgical abdomen.

Dulcolax® bisacodyl



UNDER LICENSE FROM BOEHRINGER INGELHEIM G.M.B.H. GEIGY PHARMACEUTICALS, DIVISION OF GEIGY CHEMICAL CORPORATION, ARDSLEY, NEW YORK 10502 DU-668

Medico-Legal Aspects of Human Experimentation and Transplantation

By J. Jerry Wood, J. D.

Since Christiaan Barnard's exciting and historic first successful human heart transplant operation, and even before, physicians have been concerned with special medical, ethical and legal considerations in certain patient care decisions.

The time of death and when death actually occurs has been placed in a new perspective. Obviously, it is important to establish a clear medical definition of the occurrence of death and the time when death can actually have been said to occurred. In transplantation cases some reasonable guidelines for the use of physicians involved in clinical judgments based on the time of death are necessary and important.

Improved medical technics have increased our ability to keep individuals biologically and technically alive beyond the presently accepted legal and medical definitions of death. This has, for many, raised medical legal, ethical and moral problems for physicians and surgeons.

Severe problems have been created for some families who must bear the expense of extended medical care and treatment and who experience the mental anguish that comes from having a member of the family become a virtual human vegetable.

Various committees and individual physicians have expressed themselves on a proper definition of death, including the Harvard ad hoc committee and the Mondale Commission.

When one attempts to apply the criteria established and discussed by these various committees and groups it is important to remember that the situation with which the physician is faced may be unique. The individual physician must gather data and make his judgment based on relevant facts. Some important specific situation modifiers are: Homicide cases, unusual religious beliefs, emotional instability of the family or the individual involved and any other unusual circumstances related to the case.

One major hospital committee has decided on the following medical criteria to determine death's occurrence in transplant situations. If the following criteria are present, then death has occurred:

1. Total failure of painful stimuli to produce (by transmission over nervous pathways) a reaction. This state would not be precluded by the presence of:
   a. Muscle response to direct nerve stimulation with an electrical current.
   b. Response of muscle to direct percussion or irritation.
   c. Perpipheral vasomotor responses medicated by the autonomic nervous system or as the result of pharmacologic stimuli.
2. No spontaneous respiration (i.e. patient cannot trip a respirator actuated by respiratory effort).
3. Universally absent deep reflexes (muscle-stretch reflexes) and superficial or cutaneous reflexes.
4. Absent corneal reflexes.
5. Maximally dilated pupils which are fixed to light.

6. No evidence or suggestion of awareness or consciousness on the part of the patient.

7. An isolectric EEG as defined below:

   a. No evidence of cerebral electrical activity.

   b. Maximum practical amplification for most of the recording with at least one minute of absolute maximum instrumental amplification with all filters off.

   c. Lack of evidence of cerebral response to afferent stimuli such as light, sound, cutaneous and deep pain sensation.

   d. Periodic monitoring of EKG (lead 1) and of ambient interference (as from leads on back of hand) during the recording.

   e. The findings of such an EEG condition on two occasions separated by an interval of at least six hours and preferably 24 hours.

   f. Adequate technical situation including a recommended minimum of eight scalp electrodes with a resistance (in a patient with intact circulation) of less than 10,000 ohms, and use of the widest frequentcy range amplifier response during at least part of the recording (lowest low frequency cutoff and highest high frequency cutoff).

   g. At ordinary amplification (5-10 microvolts per millimeter) such tracings will appear "isoelectric" except for EKG and obvious artifact.

8. Elimination of the possibility that any of the findings above might be the reresult of a metabolic or toxic condition such as hypothermia or administration of sedatives or anesthetics.

Certain responses mediated entirely at a

—The lowest priced tetracycline—nystatin combination available—



brain stem level and the presence of some of these responses does not necessarily rule out irreversible necrosis of the cerebral cortex and death within the scope of the definition given above. These signs are:

1. Dilated pupils which react very poorly to light.
2. Vertical following of moving objects by the eyes which cannot be carried out on command.
3. Eye movements in response to rapid head turning or caloric irrigation of the ears.
4. Withdrawal responses of the extremities mediated by the spinal cord.
5. Swallowing, yawning or vocalization brain stem reflexes.
6. Active or hyperactive deep reflexes.
7. Present corneal reflexes.
8. Responsivity using spinal or brain stem reflexes to stimuli not necessarily noxious but in which the entire response could be mediated by structures at or below the upper midbrain.

Obviously, as new knowledge is developed the medical definition of death must be adaptable and flexible. Some authorities have suggested that death should be determined by measuring the oxygen consumption of the brain. Ultimately, the burden of proof and the responsibility for determining the time of death, especially where the "dead" person is a potential organ donor, rest heavily upon the shoulders of the responsible physician.

The general public has a vested interest in human experimentation and the generation of new knowledge. It has been said that physicians must experiment in order to develop new knowledge and technics to cope with disease.

Questions have been raised about experimentation in one patient not for his benefit but for patients in general. Many patients are in the painful position of not being properly informed about the risks to which they are being exposed. Physicians must understand *informed consent.* However, sometimes the physician is in the position of not really knowing what the risks are in a given situation. For example, a significant number of a group of surviving kidney transplant patients have developed types of cancer after "successful" renal transplants. On the basis of available data, physicians are unable to say whether this is due to immunosuppressive drugs used to combat rejection or whether it relates to the presence of the foreign organ tissue itself.

There is no question but what we must continue to generate new knowledge in order to meet medical challenges we face. The question, however, is how honest and how moral

(Continued on Page 492)

Not just a motel
it's a Guest House

. . . with 171 handsome rooms designed for your comfort and convenience. A center-of-everything location including Birmingham's University of Alabama Medical Center . . . making The Guest House a favorite of Doctor's wives and in-town outpatients. Superb dining, dancing and nightly entertainment. Come stay with us often.

THE RESTAURANT
THE PLAYROOM • CYPRESS ROOM
CONVENTION FACILITIES



The Guest House
MOTOR INN

PHONE 324-8653
18TH ST. &
10TH AVE., SOUTH
BIRMINGHAM, ALABAMA

"Where the Action Is!"

and how ethical and how legal our approaches to developing this knowledge will be.

Each physician should be informed in order to render the best possible patient care to his patients. The following bibliography may be useful in this regard.

Bibliography

1. Adrian, John—Unconscious Patient, Postgraduate Medicine, Dec. 1968, p 127-129.

2. AMA Law Division—The Time of Death, JAMA, 206/11:2603-2604, Dec. 9, 1968.

3. Amer. J. of EEG Technol.—EEG Recording in Intensive Care Units, 8/3:85-95, Sept. 1968.

4. Arnold, John D., M. D., Zimmerman, Thomas F., Ph. D. and Others—Public Attitudes and the Diagnosis of Death, JAMA., 206/9:1949-1953, Nov. 25, 1968.

5. Ayd, F. J.: When is a Person Dead? Medical Science, 18:33-36, April, 1967.

6. Bard, B. and Fletcher, Jos.: The Right to Die, Atlantic, April 1968, page 59-64.

7. Beecher, Henry K.: Ethical Problems Created by the Hopelessly Unconscious Patient, New Eng. J. Med., 278:1425-1430, June 27, 1968.

8. Church Assembly Board for Social Responsibility Decisions about Life and Death, The Church Information Office, Church House, London, 1965.

9. Daube, David: Transplantation, Acceptability of Procedures and the Required Legal Sanctions, Ethics in Medical Progress, 188-190.

10. De Bakey, M. E.,: Human Cardiac Transplantation, J. Thorac Cardiovasc. Surg., 55:447-451, March 1968.

11. Dobson, S.: What is Death, Recorder, 6/3:16-18, 1968, July.

12. Editorial, What and When is Death, JAMA, 204/6:423-425, May 6, 1968.

13. Editorial, When Do We Let The Patient Die?, Ann. Int. Med., 68:695-700, March, 1968.

14. Ethics in Medical Progress, Ciba Foundation (London, J. & A. Churchill, 1966) 69-74.

15. Gaevskaya, M. S.,: Biochemistry of the Brain During the Process of Dying and Resuscitation, State Press, Moscow, 1963, Transl. J. A. Stekol, Consultation Bureau, New York, p 101, 1964.

16. Gastaut, H., & Meyer, J. S.: Cerebral Anoxia and the EEG, Thomas, Springfield, Ill., 617, 1961.

17. Glaser and Strass,: Awareness of Dying, p. 194-203, Chicago, Aldine, 1965.

18. Halley, M. Martin, and Harvey, William F.: Medical vs. Legal Definitions of Death, JAMA, 204/6: 423-425, 1968.

19. Hamner, Reginald T.: Legal Death, Can it be Defined, J. Med. Assoc. Ala., 610-613-614, Jan. 1969.

20. AMA J.: A Definition of Irreversible Coma, 205:337-340, Aug. 5, 1968.

21. Jonesco, Sisesti, Sagart, N. & Kreindler A.: The EEG in Comatose State and After Death (Electroencephalogramme Pendant le Coma et Apres la Mort) Bull. Sect. Scient. Acad. Roumaine, 22:391, 1946.

22. Judicial Council: Ethical Guidelines for Organ Transplantation, 205:341-342, Aug. 1968.

23. Kimura, Jun, et al: The Isoelectric EEG, Arch. Int. Med., 121:511-516, June 1968.

24. Lewin,: Severe Head Injuries; Symposium on the Cost of Life, Proceed. Roy. Med. Soc., 1210, Nov., 1967.

25. McGeown, M. A.: Ethics for the Use of Life Donors in Kidney Transplantation, Amer. Heart. U., 75:711-715, May 1968.

26. Medicoleg J.: The Moment of Death, 31:195-196, 1963.

27. Modern Medicine, Significance of Isoelectric EEG in Drug Coma, 72, Dec. 16, 1968.

28. Moracewski, Albert,: The Hopelessly Unconscious Patient, Post-Graduate Medicine, 127-129, Dec. 1968.

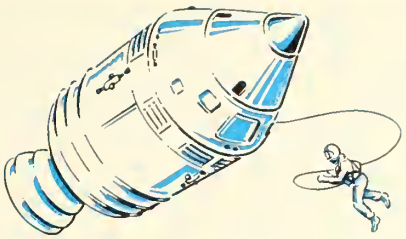
29. Schwab, Robert S. & Young, Robert R.: Irreversible Coma, Network for Continuing Medical Education, 342 Madison Avenue, New York, N. Y., 10017.

30. Silverman, Daniel: Report of the Ad Hoc Comm. of the American EEG Society of Criteria for Determination of Cerebral Death, Reprint request to Graduate Hospital, 19th and Lombard Street, Phil. Pa., 19146.

31. Spoeral, W. E.: The EEG after Cardiac Arrest, Canad. Anesth. Soc. J., 479-487, 1962.

32. Voight, J.: The Criteria of Death Particularly in Relation to Transplantation Surgery, World Med. J., 14:143-146, Sept., Oct. 1967.

33. Woodruff, MFA: Ethical Problems in Organ Transplantation, Brit. Med. J., 1:1457-1460, June 6, 1964.



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals



Appearances may be deceiving



It may be tetracycline

but it's not ACHROMYCIN® V
Tetracycline HCl

unless it bears this signature.



250 mg. and 100 mg. capsules

Contraindications: Hypersensitivity to tetracyclines. *Warning:* In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs. *Precautions:* Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

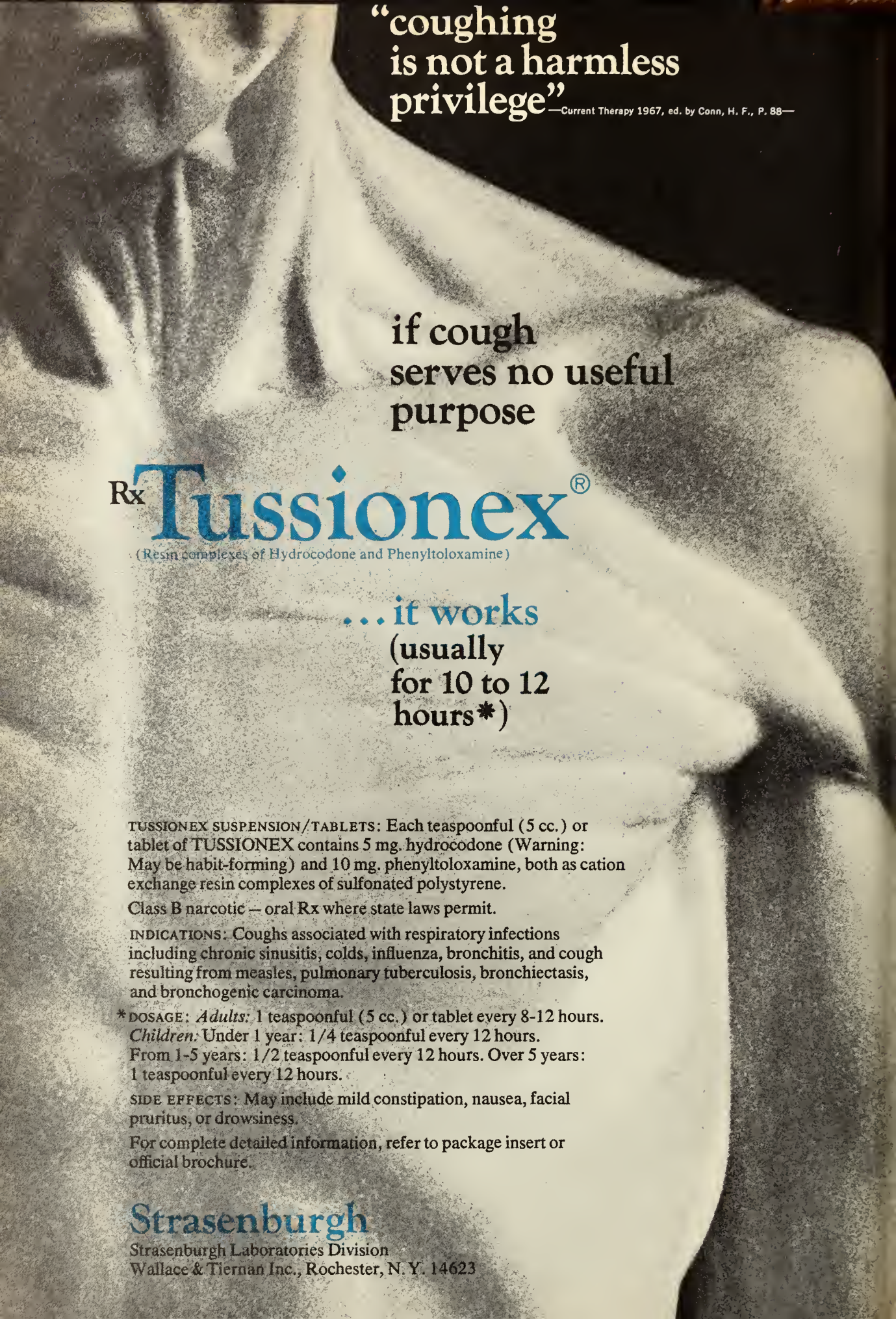
Side Effects: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

530-9



"coughing is not a harmless privilege"—Current Therapy 1967, ed. by Conn, H. F., P. 88—

if cough serves no useful purpose

Rx Tussionex®

(Resin complexes of Hydrocodone and Phenyltoloxamine)

... it works (usually for 10 to 12 hours*)

TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic — oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N. Y. 14623



The Month in Washington

From the Washington Office
American Medical Association

Washington, D. C.—Health, Education and Welfare Secretary Robert Finch has asked a special Task Force on medicaid to examine and make recommendations on proposals for a sweeping national health program.

The Task Force, headed by Walter J. McNerney, president of the Blue Cross Association, is scheduled to issue a report about the first of the year.

After referring to a proposal for universal health insurance endorsed by many governnors at the National Governors' Conference, Finch told McNerney in a letter:

"I would like specifically to request that the Task Force consider, along with its other deliberations on medicaid and related programs, what directions and initiatives you feel the HEW Department should pursue in this area."

According to McNerney, one phase of the study would include the extension of medicare to persons of all ages, roughly the national compulsory health plan backed by Walter Reuther of the United Auto Workers and his Committee of 100 for National Health Insurance.

McNerney, however, also said that all types of mass plans would be studied, including the health insurance tax credit proposal endorsed by the American Medical Association.

The rapidly rising costs of medicare and medicaid have brought the issue to the forefront. The Administration said older people who enter the hospital after January 1 will have to pay for an additional $8 of their hospital bills due to the higher costs. The increase is required by law.

The benefit cutback results from an adjustment of the portion of the hospital bill for which a medicare beneficiary is responsible if these costs have risen substantially.

* * *

After a two-year study, Sen. Abraham Ribicoff (D., Conn.), former HEW Secretary, said he's reached the conclusion the federal health effort "is a planless conglomeration of programs administered by more than a score of agencies and departments."

Federal health spending "instead of supporting programs to provide for the health of the people . . . is maintaining a cumbersome, disjointed bureaucracy that even key government officials have difficulty managing," he told the Senate.

"Instead of eliminating problems, (they) may be adding to factors such as rising costs, limited access to care and the fragmented organization of health services."

"There are so many programs administered in such bureaucratic confusion that no one —not the HEW Department, not the Bureau of the Budget nor any private organization was able to tell the subcommittee even how many programs there are."

* * *

The American Medical Association told Congress drug dependent persons should be treated as patients rather than criminals.

In testimony before the Senate Juvenile Delinquency Subcommittee, Henry Brill, M. D., chairman of the AMA's Committee on Alcoholism and Drug Dependence, said physicians are concerned over legislation before the Subcommittee proposing harsher penalties for persons unlawfully possessing drugs for their personal use.

"Mere possession for personal use of de-

pressant and stimulant drugs having a legitimate medical usage should not constitute an offense," Dr. Brill said. "The degree of social hazard and the reasons for having the drug should be taken into account."

"With respect to the entire section on offenses and penalties, we propose an amendment to direct courts to appoint a panel of medical experts in each case where a drug abuser is brought to trial on a charge of illegal possesison and where, in the court's opinion, medical treatment may be indicated. The panel would make a determination as to whether the defendant has a medical problem associated with his abuse of drugs—a physical or psychological disability or drug dependence.

"If medical treatment is indicated, the panel would recommend to the court the type of treatment needed—that is, general—medical or psychiatric care; in-patient hospitalization or clinical treatment; group therapy; half-way house etc. If medical treatment is not indicated, or if measures in addition to medical treatment are needed, the court would then consider the non-medical handling of the case."

Under the proposed AMA changes, the HEW Department, rather than the Justice Department, would control the official classification of drugs, and the research and public education programs in the field. Control provisions would focus on manufacturers and distributors, rather than on physicians.

"We recommend that as a matter of public policy Congress explicitly charge the HEW Department with the major responsibility for research on all aspects of drug abuse and dependence other than enforcement," said Dr. Brill.

The AMA supports provisions in the legislation "which would allow researchers to withhold names of subjects, and to handle controlled drugs without prosecution, especially on state and local levels, has served to hamper needed research in the past."

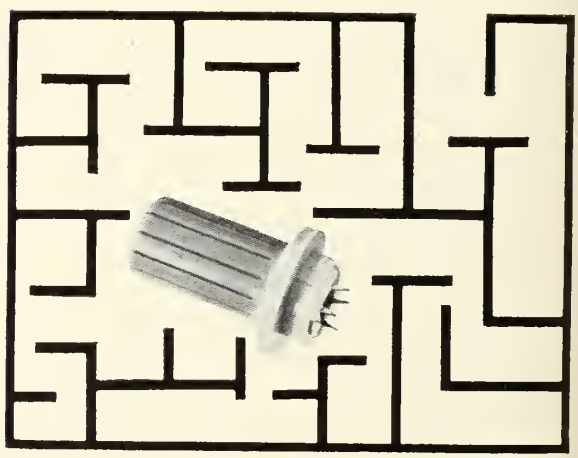
* * *

The American Medical Association supported legislation to require foreign medical graduates trained in this country to spend two years of residence in their native land or land of previous residence before becoming eligible to apply for U. S. citizenship.

C. H. William Ruhe, M. D., director of the AMA's Division of Medical Education, said the measure would strengthen the Exchange Visitor Program. However, Dr. Ruhe suggested that the provision be strengthened to require that citizens of less-developed nations return to their home countries rather than their latest nation of residence. He cited the example of citizens of India who come to the United States from England.

"If such participants are required merely to return to England there will be no alleviation of the brain drain from India," he told the House Judiciary Subcommittee on Immigration.

* * *



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST
(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

473-9

The HEW Department's Children's Bureau was broken into separate health and welfare units.

Under the reorganization:

* Health programs administered by the Children's Bureau were transferred to the Health Services and Mental Health Administration (HSMHA) where they will form a new organizational unit. Programs included are for maternal and child health services, crippled children, maternity and infant care, and health of school and pre-school children.

* The Children's Bureau as such goes from the Social and Rehabilitation Service to the Office of the HEW Secretary, where it becomes part of the new Office of Child Development. The Bureau will maintain its role of leadership and coordination of child and parent programs throughout the Department. It will also continue to investigate and report on all matters pertaining to the welfare of children.

* Community services administration is established in the Social and Rehabilitation Service to consolidate the administration of social service programs for children and adults. These include programs located previously in the Children's Bureau and in other agencies of the Social and Rehabilitation Service.

"I expect the Office of Child Development and the Children's Bureau to be vigorous advocates of the interests of children," HEW Secretary Robert Finch said. "They will work directly with public and private agencies to stimulate improvements in the availability and quality of services to children and parents, and to work with all agencies of HEW."

Secretary Finch said that maternal and child health programs will be strengthened by their placement in HSMHA. "All of the health programs administered by HSMHA should benefit from this new and closer relationship," the Secretary said.

Obsolescent Doctors, Hospitals

"Ninety per cent of what the physician does for his patient is basic and not subject to obsolescence," reads a prefatory note introducing the first half of the above caption: "Obsolescent Doctors," then it continues:

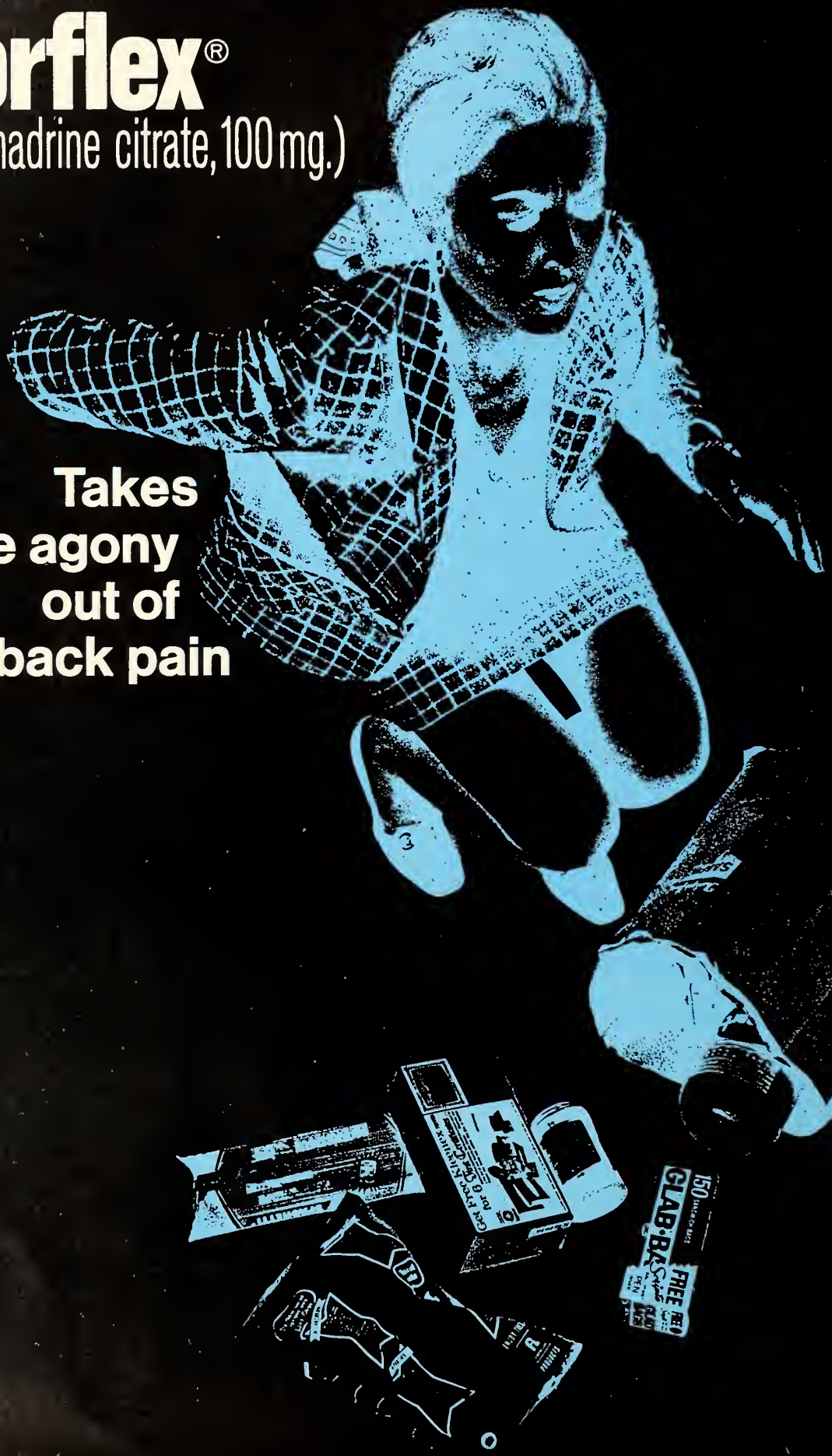
"But the remaining ten per cent distinguishes the physician from the cultist and the faith healer, for it is the scientific knowledge that has a half-life of five years. Physician obsolescence can come from six sources —ourselves, our numbers, the town-gown controversy, the government-money-computer axis, the hospital, and the methods of delivering medical care."

Thereafter follows an examination of the six sources of obsolescence, carrying the byline of Robin W. Bell-Irving, M. D., Vancouver, British Columbia, and published in *Northwest Medicine.*

"Obsolescence in hospitals occurs because of lack of progressive thinking at all levels," argues F. W. B. Hurlburt, M. D., also of Vancouver, who bylines the second half of the essay, that treating of Obsolescent Hospitals, and he continues:

"If we are to keep up with the change, we must totally revise our concept of the function of hospitals within the community, of hospitals as fixed plants, and administrative, medical and paramedical personnel must cooperate in the team approach to medicine. We must constantly keep renewing our professional staff and we must apply political pressure to governing bodies to give hospitals the necessary approval and finances to do the job. We must also realize that the practice of medicine is due to change drastically in the next decade and the medical profession must lead the way in making these changes, and be prepared to advise government in this respect."

Norflex®
(orphenadrine citrate, 100 mg.)



Takes the agony out of low back pain

Take the agony out of low back pain... Norflex® (orphenadrine citrate) relaxes the muscles in spasm.

Restore mobility and hasten recovery... prescribe Norflex 1 tablet b.i.d.

Indications: Acute spasm of voluntary muscles, regardless of location; especially post-traumatic, discogenic, and tension spasms. **Contraindications:** Due to its anticholinergic action, NORFLEX should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcer, prostatic hypertrophy or obstruction at the bladder neck, cardiospasm (megaesophagus) and myasthenia gravis. Use with caution in patients with tachycardia. Do not use propoxyphene (Darvon®) concurrently. **Adverse Reactions:** Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Adverse reactions are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported. **Dosage and Administration:** Two tablets per day for adults, regardless of weight or sex; one in the morning and one in the evening. Each tablet contains 100 mg. orphenadrine citrate.
For full information, see Package Insert or P.D.R.

Norflex®
(orphenadrine citrate)

Riker Laboratories
Div. of Dart Industries Inc.
Northridge, California 91324

The Riker representatives in your area are:
Robert Johnston
Billy J. Phillips
William O. Crabb
Paul E. Loeffler III

Red—A Danger Signal

"Reaching from Peiping to New York, the long arm of Maoism struck at the AMA," William F. Watts, M. D., president of the Washington State Medical Association, wrote in *Northwest Medicine,* reporting on the convention disturbance of last summer in New York.

"I arrived a little late at the opening session of the AMA House of Delegates; the large hall was overflowing, with people standing along the walls. I found myself standing next to a squad of excited youths."

They and a group seated on either side of the central aisle were "easily identified by their garb, hair styles, beards or mustaches, smell or feverish look. Most wore badges with outhouse wall inscriptions attacking AMA. A few were young physicians or medical students. . .

"While the meeting went on with its semiformal proceedings, the Maoists continued their buzzing and activities. They pointedly sat down during the flag salute. They booed and hissed every symbol of patriotism. They clearly intended to (1) annoy and create dramatic reaction, and (2) obtain a maximum of free publicity. . . To millions of viewers they gave the impression there surely is something wrong with this AMA that has so frequently been besmirched by the news media, and now is attacked by its own young doctors. . .

"We can be tolerant, if we have to, up to a point—even when we know the source of the abuse heaped on us. But there is also a time for firmness. When the time is well chosen, it works."

Longevity Today Can Be Assured For Most Of Us

People are living longer and will continue to live longer and longer; more than that, medical science can generally guarantee it.

This well documented statement is established in the annual report (1968-69) of the Life Insurance Medical Research Fund, just released, from which the following paragraphs are quoted:

HYPERTENSION

"The past twenty years have witnessed a decline of 58.9 per cent in deaths due to hypertension (high blood pressure) and related diseases. In addition, proper treatment can now extend the lives of individuals with severe hypertension from 1.5 to 5 years. These gains stem from intensive research resulting in the development of effective drugs to combat hypertension. The Fund's share of this research effort to date has been $1,621,405. . . "

CARDIAC SURGERY

"Cardiac surgery has advanced remarkably in the past 15 years. Most congenital heart defects can now be repaired; malfunctioning mitral and aortic valves can be replaced with artificial ones; arteries can be repaired; and now even whole hearts can be transplanted. As a result, insurance protection is gradually becoming available to individuals whose heart defects have been corrected. Until the very recent past, such individuals were uninsurable. The Fund has invested $713,697 in the projects of 23 investigators studying ways to improve heart surgery. . . "

DIABETES

"Prior to 1940, diabetics were generally considered uninsurable. Within a few years, several life companies were accepting selected diabetics on an experimental basis, charging substantial extra premiums. As improved methods of treatment have been developed through research, insurance companies have been able to liberalize their underwriting of diabetics, until now increasing numbers of individuals so afflicted are able to obtain protection. . . "

ARTERIOSCLEROSIS

"Especially in coronary artery disease, Arteriosclersosis represents the largest of the Fund's long-term investments—$2,198,472 to 60 individuals. Prior to 1945, very few companies would insure individuals so afflicted and mortality was high among policyholders developing such conditions in later life.

"Intensive research to date has succeeded in providing some answers about prevention (through proper diet and exercise) and treatment, especially of acute cases (through hospital coronary care units). Consequently, life companies now underwrite certain groups of individuals with histories of arteriosclerosis; and, thousands of policyholders are still alive after suffering atacks that would have been fatal twenty years ago. The battle is far from won, however, and so the Fund continues to support projects in this area."

In a summarizing article in the same report, William A. Soderman, M. D., Scientific Director, writes:

"Jules Verne's fantastic and fictional description of a manned flight to the moon took a century to become fact. It took 18 centuries between recognition of diabetes and development of insulin to control the disease. Only 15 years elapsed between the development of the heart-lung machine and the first successful human heart transplant.

". . . Since a diseased human being cannot be experimentally tested in the same way as can a malfunctioning engine, long and painstaking efforts must be made to find out what causes his trouble, and what will prevent, alleviate, or cure it, without disastrous side effects.

"Medical research, therefore, is a very complex undertaking with methods of treatment that will avoid undue disturbances of the delicately balanced interplay of systems in the human body.

"In the near future, medical research is expected to: (1) find the answers to the cause, prevention, and treatment of atherosclerosis, chronic rheumatic disease, and certain psychiatric disorders; (2) develop safe vaccines for the prevention of rabies and leukemia; and (3) perfect transplant techniques for the human heart and other organs.

"Farther away from realization, but feasible in the light of today's discoveries, are these medical achievements: (1) nearly complete eradication of such diseases as cancer and hypertension; (2) mass production of synthetic drugs that will greatly reduce or eliminate injurious side effects commonly associated with drugs now necessarily produced from natural enzymes; and (3) prevention of the birth of mentally retarded babies."

A TV Program Especially For Medical Profession

Occasionally there is something for nothing.

In the home of each of the 51 members of MASA now practicing medicine in the City of Decatur (who has agreed to it) has been installed a little black box that will permit the M. D. to share in his leisure hours the continuing TV medical education program showing currently in 500 hospitals and medical centers over the nation, including the University of Alabama Medical Center, Birmingham.

Decatur was selected out of the cable-television towns in Alabama for this experiment that shares NCME (Network for Continuing Medical Education) programs with doctors in private practice. There will be a weekly change of program, and the individual doctor may select his own leisure-hour time for listening and looking, whether 8 to 9 a. m. or 9 to 10 p. m., any day of the week.

NCME programs originate at the major university and government medical centers with such outstanding physicians as Dr. Denton Cooley and Dr. Paul Dudley White. And each seeks to be current, clinical and practical programs covering every discipline of medicine.

Co-sponsored by Roche Laboratories, a division of Hoffman-La Roche, by CMC (Community Medical Cablecasting) of New York and by Decatur Telecable, Inc., each one-hour telecast contains three separate programs, as well as two messages on product research and development provided by Roche. There will also be in each telecast information and local medical news of interest to Decatur physicians.

Decatur Telecable, Inc., is underwriting the local transmission expense of the experiment, according to T. W. Meadows, general manager. And it is hoped, Mr. Meadows said, not only to make this a permanent feature available to Decatur doctors but to extend it to other telecable towns in Alabama, with the cooperation of MASA.

The little black box that unscrambles the private telecast programs for doctors is little larger than a box of business stationery and has no effect on the TV programs of conventional channels.

Steps In War On Unproven And Unapproved Drugs

From the Fact Sheet of HEW's Public Health Service comes the following:—

Laetrile is an unproven new drug for which there has never been an approved new drug application (NDA) on file with FDA. The Federal Food, Drug, and Cosmetic Act requires that there must be an approval of an NDA on file before a new drug may be shipped in interstate commerce. Two incomplete NDA's were submitted in 1962, one by Ernst T. Krebs, Sr., M. D., the developer, and the other by his son, Ernst T. Krebs, Jr., and his John T. Beard Memorial Foundation. New drugs not yet covered by an approved NDA may be shipped in interstate commerce for clinical investigation in humans after the filing with FDA of a Notice of Claimed Investigational Exemption for a New Drug (IND). One such IND was received on June 7, 1967, but terminated July 28, 1967, because of inadequate preclinical animal testing and other deficiencies.

The sponsors claim that laetrile is amygdalin derived from apricot kernels of a particular variety grown in California. They claim that a trophblastic component is present in every instance of cancer; that amygdalin is hydrolized by an enzyme supposedly present in excess in cancer tissue to yield, among other things, free hydrogen cyanide; that the hydrogen cyanide destroys the cancer cells but does not harm the normal cells as another enzyme present in the normal cells converts the hydrogen cyanide into other substances.

Although laetrile has had considerable use throughout the world, no well documented cases of therapeutic efficacy ascribed to laetrile have ever been presented to FDA. The California Cancer Commission has investigated laetrile with the conclusion that it was of no value in cancer treatment. The National Cancer Institute has tested it against tumors in animals under the National Cancer Chemotherapy Research Program with negative results.

Ernst T. Krebs, Sr., M. D., and his son Ernst T. Krebs, Jr., have persistently distributed laetrile and other new drugs commercially for many years, and have stopped these acts only when forced to do so by the Courts. Likewise, an affiliate, the McNaughton Foundation in Montreal, acted in defiance of the Canadian Government, and distributed laetrile for treatment purposes until that Government exercised its seizure authority. A criminal information was filed against Krebs, Jr., and his John T. Beard Memorial Foundation in the Federal Court at San Francisco in 1961, for the interstate distribution of another unproven new drug known as pangamic acid. The defendants pleaded guilty and were fined. Krebs, Jr., was placed on probation for three years. As a condition of his probation he was prohibited from making interstate shipments of any new drugs, specifically including laetrile, until he had an effective NDA filed with FDA. When FDA found evidence of repeated interstate shipments of laetrile by Dr. Krebs a complaint for injunction was filed against him in the Federal Court at San Francisco in May, 1965. A restraining order was granted, but Dr. Krebs continued to make shipments. He subsequently consented to a decree of permanent injunction. The injunction is still in effect. On January 27, 1966, Dr. Krebs pleaded guilty to criminal contempt arising out of his repeated violations of the restraining order. Dr. Krebs, who was about 87 years of age at the time, was placed on probation for one year. He violated the probation by shipping laetrile. He was fined and ordered to make no more sales.

Unless and until the claims made by the sponsors of laetrile can be substantiated by well controlled scientifically conducted preclinical studies, laetrile should not be administered to humans under any circumstances.

The AMBAR® SCRAPBOOK of

Obesity Oddities

FACT & LEGEND

OBESITY WAS A MILITARY OFFENSE!

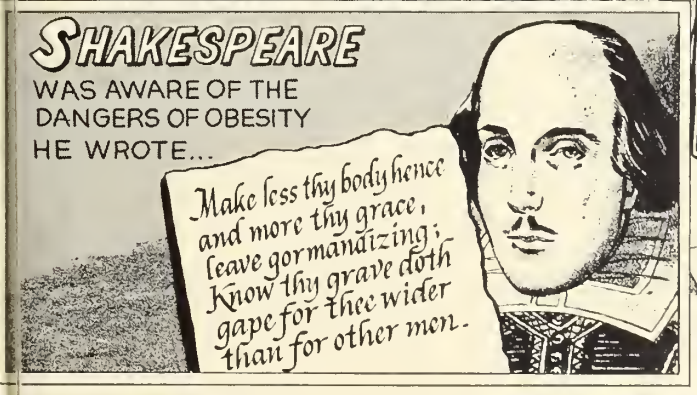
OVERWEIGHT ROMAN HORSEMEN WERE MADE TO FORFEIT THEIR MOUNTS AND BECOME FOOT SOLDIERS!

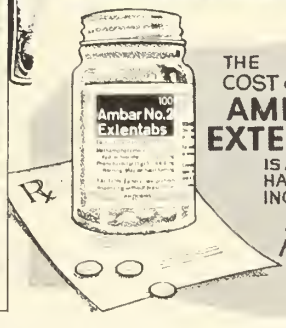


RECORDED ON AN ENGLISHMAN'S TOMBSTONE

SHAKESPEARE

WAS AWARE OF THE DANGERS OF OBESITY HE WROTE...





THE COST OF **AMBAR EXTENTABS** IS APPROXIMATELY ONE HALF THAT OF OTHER LEADING APPETITE SUPPRESSANTS

AN IMPORTANT FACTOR IN LONG TERM THERAPY

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69

World's Remotest Corners May Help Subdue Cancer

The National Cancer Institute, National Institutes of Health, has embarked on a worldwide search for isolated groups of people with special genetic constitutions, from whom scientists can obtain tissue specimens to aid in the identification of viruses that may cause human cancer.

Dr. Albert B. Sabin, one of the scientists responsible for the eradication of poliomyelitis, now studying the virus-cancer problem, is directing an Institute-supported project to detect a human sarcoma virus. The noted virologist, for more than 30 years at the Children's Hospital Research Foundation, University of Cincinnati, is trying a new and unique approach in the search for a human virus that might be comparable to the sarcoma viruses of chickens, mice and cats.

Dr. Sabin plans to develop about 100 tissue culture cell lines derived from population groups that are highly isolated, either socially or geographically, in the hope of finding cells that are both genetically receptive to and at the same time free of cancer viruses. Extracts of 80 human sarcoma specimens of bone and soft tissue obtained from surgical patients are concentrated by centrifugation, then placed on the cell cultures. Each culture is watched for a "focus," or an outgrowth of a small number of transformed cells into little tumors, the presence of which would indicate the existence of a human sarcoma virus transmitted from the tumor extract to the cell culture. If no "focus" appears, all the cells are subcultured to detect any outgrowth of transformed cells that may have been missed in the cultures initially exposed to the sarcoma extract. It is this procedure of subcultures that adds a tremendous amount of labor to the project.

The tissue specimens for starting the culture cell lines are pieces of skin, each smaller than a pea, obtained by biopsy. The biopsy process is painless and easily accomplished with the aid of a punch device and a local anesthetic.

It is important, National Cancer Institute scientists point out, to obtain the skin from isolated peoples who hopefully may not have been exposed to the special viruses that are the target of the studies. Several specimens have been obtained from a few population groups, but it is expected that many more will be collected in the near future.

The Havasupai Indians, a tribe that has lived by itself on the floor of the Grand Canyon for ten centuries, cooperated by producing 18 volunteers in one afternoon. Twenty-one residents of the island of Saba, in the Netherlands Antilles, east of the Virgin Islands, offered to give skin samples. These people, fishermen of Dutch ancestry, number about 1100, but there are no more than four or five family names on the island.

The Samaritans of Israel, socially isolated from the rest of their compatriots since biblical times, have volunteered to participate. In Sappada, a community of people of German descent in the Italian Alps physically isolated from their neighbors by rugged mountain terrain since the thirteenth century, one person has volunteered so far, and the investigators are hopeful more will do so.

Other suitable population groups will be approached in the hope of obtaining cooperation in the project. Some of the groups are the Apache, Pima, and Hopi Indian tribes of Arizona; a community of French people on St. Thomas, Virgin Islands; Hawaiians from the outer islands; the tribes of West Africa; and the insular residents of Tangier Island, in lower Chesapeake Bay.

Alabama Department of Public Health

Pesticide Program Begun

By William A. Coniglio

Since the beginning of civilization, man has sought to conquer the many problems encountered in the production of food, fiber, and the prevention of arthropod borne disease. Early efforts centered on the use of inorganic and biological extracts. Many of these products were of limited value. The discovery of synthetic insecticides provided man with his first real weapons. An extremely rapid proliferation of pesticides followed. Today pesticide research, development, manufacture, and distribution are major industries. In 1968, 303 pesticide manufacturers and formulators registered over 3,000 products with the Alabama State Department of Agriculture. Usage on the farms, homes, lakes, woodlands, and right-of-way of Alabama is extensive, yet the amount of insecticides, fungicides, rodenticides, herbicides, and defoliants used in Alabama is unknown. Many of these compounds are innocuous but some are extremely toxic to man.

Pesticides confront us in ever increasing amounts. Contrary to common belief, you do not have to deal directly with sprays or dusts to be exposed. Pesticides are in the food we eat, the air we breathe, the products we use, and the homes in which we live. As a result, our bodies must cope with a pesticide burden; no one is immune. Since pesticide exposure is inescapable, it behooves us to study usage and exposure patterns and to enact those programs which will allow humanitarian benefits to be harvested without endangering the health and environment of Alabamians.

On April 1, 1969, a pesticide program was initiated by the Alabama Department of Public Health. The missions assigned to the pesticide program are listed below:

1. Patterns of pesticide usage: Studies have been initiated which will determine the kind and amount of pesticide being used locally. These investigations will culminate in a synthesis of data concerning principal users, manufacturers, formulators, agricultural and domestic pesticide applicators, and greenhouse activities. A final tabulation of this information should provide a stable foundation upon which future directives will be built.

2. Pesticide morbidity and mortality: Working through the existing reporting system, data on illness and death associated with pesticides usage will be compiled. As an accurate pattern of human involvement emerges, educational programs will be developed to emphasize that pesticide poisonings are preventable.

3. Disposal of pesticide waste: All available technology will be focused on the solution of local problems created by pesticide disposal. A survey of disposal problems encountered by manufacturers, formulators, and users will be initiated. In addition, liaison with existing state and federal agencies should extract proper transportation and storage methods and establish a network to cope with accidental pesticide spillage.

Mr. Coniglio is Project Director, Pesticide Program, Alabama Department of Public Health.

4. Pesticide ordinances: A review of state and local pesticide ordinances will be conducted. If desired by the appropriate authority, assistance will be offered to develop a comprehensive base for pesticide regulation.

5. Environmental contamination: State pathologists will be contacted in an effort to establish a human monitoring program. This monitoring system will seek data on the degree of pesticide storage in Alabamians.

6. Training: In-service training will be developed at the state and community levels to increase awareness of pesticide epidemiology and the safe use of pesticides. If desired, individual workshops will be developed for those service professions which become involved with pesticides.

7. Laboratory competency: Specialized training will be made available to selected chemists working in the field of pesticide analysis. Efforts will also be directed toward improving analytical equipment and developing laboratory capability.

8. Pesticides in air: Air sampling for pesticides will be conducted as a routine activity. Surveys will be conducted on a problem site basis. This data should provide a base upon which occupational health standards may be examined.

All activities are aimed at creating increased pesticide awareness among the professional community. Only when this has been completed will the full potential of a comprehensive pesticide program be realized.

BUREAU OF PREVENTABLE DISEASES

Frederick S. Wolf, M. D., Director

Current Morbidity Statistics
1969

	June	July	*E. E. July
Tuberculosis	115	97	125
Syphilis	67	48	145
Gonorrhea	433	678	406
Chancroid	1	0	1
Typhoid fever	0	0	1
Salmonella	21	18	6
Undulent fever	0	0	0
Shigella	3	4	10
Amebic dysentery	0	1	3
Scarlet fever & strep. throat	294	363	136
Diphtheria	0	0	1
Whooping cough	2	7	13
Meningitis	3	5	3
Tularemia	0	0	0
Tetanus	1	1	2
Poliomyelitis	0	0	1
Encephalitis	0	2	0
Smallpox	0	0	0
Measles	2	1	74
German measles	5	1	8
Chickenpox	9	11	14
Mumps	5	4	30
Infectious hepatitis	23	25	53
Typhus fever	0	0	0
Malaria	2	0	0
Cancer	548	1,341	655
Pellagra	0	0	1
Rheumatic fever	15	6	16
Rheumatic heart	16	19	20
Influenza	47	28	20
Pneumonia	216	220	167
Rabies—Human cases	0	0	0
Pos. animal heads	0	5	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.



BUREAU OF VITAL STATISTICS
PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA

Ralph W. Roberts, M. S., Director

MARCH 1969

Live Births / Deaths / Causes of Death	Number Recorded During April 1969			Rates* (Annual Basis)		
	Total	White	Non-White	1969	1968	1967
Live Births	4,726	3,252	1,474	15.8	16.9	16.2
Deaths	2,723	1,860	863	9.1	8.9	8.6
Fetal Deaths	75	31	44	15.6	23.1	18.8
Infant Deaths—						
under one month	81	43	38	17.1	17.6	19.1
under one year	12	57	55	23.7	24.6	26.9
Maternal Deaths	3		3	6.2	3.9	10.3
Causes of Death						
Bacillary dysentery, amebiasis, 004, 006						
Enteritis, other diarrheal diseases, 008, 009	5		5	1.7	†	†
Tuberculosis, all forms, 010-019	16	5	11	5.3	4.4	6.5
Diphtheria, 032						
Whooping Cough, 033					0.3	
Meningococcal infections, 036	2	1	1	0.7		1.0
Poliomyelitis (acute), 040-043**						
Measles, 055						1.0
Syphilis, 090-097					2.4	0.7
Malignant Neoplasms, 140-209	416	298	118	138.8	129.0	122.6
Diabetes Mellitus, 250	55	37	18	18.4	17.3	14.3
Major cardiovascular Diseases, 390-448	1,370	970	400	457.2	†	†
Diseases of heart, 390-398, 402, 404, 410-429	926	667	259	309.0	306.3	289.2
Rheumatic fever & heart, 390-398	11	7	4	3.7	†	†
Hypertnesive heart & renal disease, 402, 404	25	10	15	8.3	†	†
Ischemic heart disease, 410-414	792	585	207	264.3	†	†
Cerebrovascular disease, 430-438	348	242	106	116.1	124.2	112.3
Diseases of the arteries, 440-448	80	54	26	26.7	24.0	24.2
Influenza, 470-474	6	6		2.0	0.7	1.0
Pneumonia, 480-486	80	52	28	26.7	20.6	20.8
Bronchitis, emphysema, asthma, 490-493	39	34	5	13.0	†	†
Appendicitis, 540-543	2	1	1	0.7		0.3
Hernia, intestinal obstr., 550-553, 560	8	2	6	2.7	2.7	3.4
Cirrhosis of liver, 571	17	15	2	5.7	4.7	6.1
Complications of preg., childbirth, 630-678	3		3	6.2	3.9	10.3
Congenital anomalies, 740-759	17	13	4	3.6	4.4	5.7
Immaturity, 777	21	12	9	4.4	4.8	4.6
Accidents, total, 800-949	210	164	46	70.1	67.7	68.3
Motor vehicle accidents, 810-823, 940	128	107	21	42.7	35.5	34.1
All other defined causes	313	185	128	104.5	119.2	117.8
Symptoms & ill-defined, 780-796	143	65	78	47.7	45.0	46.4

Down Memory Lane

The following paragraphs lifted directly from the September, 1919, issue of Nebraska State Medical Journal, are reflective of the differences of half a century:

"Our most valuable aids in the diagnosis of obscure aortic disease are the Wasserman test and the Roentgen ray . . .

"In France, the University of Nebraska Red Cross Base Hospital No. 49, to which I was attached, was ordered to Allerey. At this point collapsible wooden barracks had been erected for ten base hospitals of 1,000 beds each with an emergency extension in tents for each hospital of a thousand additional beds. . .

"Beyond question the vast majority of pulmonary conditions can be clearly demonstrated on a single plate . . .

"The medical profession should stand as a body back of universal military training—not as a militaristic measure—but from the sanitary side and for the economic gain to the community which that side represents . . .

"The way in which the United States Government has perfected its draft selection has been called 'the finest demonstration ever made of local self-government, . .

"Aviation (in World War I) was new, and the surgeon general's office found that there would be problems in aviation which differed somewhat from the usual task of the army surgeon."

* * *

*Rates: Births and deaths—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

**Does not include late effects

† NOTE: The Eighth Revision of ICD (New Revised Code) is used beginning with January 1969. Comparison with statistics compiled under the former Code (Seventh Revision ICD) and rates cannot be made. Direct to the Alabama Bureau of Vital Statistics any question about comparability of statistics compiled and rates under the new vs. the former ICD.

BUREAU OF VITAL STATISTICS
PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA.

Ralph W. Roberts, M. S., Director

MAY 1969

Live Births / Deaths / Causes of Death	Number Recorded During April 1968			Rates* (Annual Basis)		
	Total	White	Non-White	1968	1967	1966
Live Births	4,785	3,306	1,479	15.4	16.3	15.7
Deaths	2,653	1,852	801	8.6	8.3	9.0
Fetal Deaths	102	57	45	20.9	18.4	22.2
Infant Deaths under one month	109	62	47	22.8	19.1	21.6
under one year	145	80	65	30.3	24.2	28.3
Maternal Deaths	2	1	1	4.1	5.9	4.1
Causes of Death						
Bacillary dysentery, amebiasis, 004, 006						
Enteritis, other diarrheal diseases, 008, 009	5	3	2	1.6	†	†
Tuberculosis, all forms, 010-019	17	9	8	5.5	4.6	7.3
Diphtheria, 032						
Whooping Cough, 033						
Meningoeoeeal infections, 036	2	1	1	0.6	0.7	0.7
Poliomyelitis (aeute), 040-043**						
Measles, 055						0.3
Syphilis, 090-097	1		1	0.3	0.3	0.7
Malignant Neoplasms, 140-209	390	289	101	126.0	121.9	137.1
Diabetes Mellitus, 250	59	42	17	19.1	12.3	16.8
Major eardiovaseular diseases, 390-448	1,333	972	361	430.5	†	†
Diseases of heart, 390-398, 402, 404, 410-429	946	708	238	305.5	268.0	315.6
Rheumatie fever & heart, 390-398	16	13	3	5.2	†	†
Hypertensive heart & renal diseases, 402, 404	26	14	12	8.4	†	†
Isehemic heart disease, 410-414	805	611	194	260.0	†	†
Cerebrovascular disease, 430-438	319	210	109	103.0	120.9	119.3
Diseases of the arteries, 440-448	55	48	7	17.8	15.7	20.2
Influenza, 470-474	1	1		0.3		1.0
Pneumonia, 480-486	56	29	27	18.1	22.9	19.5
Bronehitis, emphysema, asthma, 490-493	41	37	4	13.2	†	†
Appendicitis, 540-543	1	1		0.3		
Hernia, intestinal obstr., 550-553, 560	5	3	2	1.6	2.9	3.6
Cirrhosis of liver, 571	27	22	5	8.7	6.9	7.9
Complications of preg., childbirth, 630-678	2	1	1	4.1	5.9	4.1
Congenital anomalies, 740-759	30	23	7	6.3	3.8	5.9
Immaturity, 777	30	12	18	6.3	5.2	6.7
Accidents, total, 800-949	186	128	58	60.1	68.8	67.4
Motor vehiele accidents, 810-823, 940	106	73	33	34.2	39.6	30.1
All other defined causes	334	225	109	107.9	121.5	111.4
Symptoms & ill-defined, 780-796	133	54	79	43.0	47.8	48.9

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from speeified eauses—per 100,000 population

**Does not inelude late effects

NOTE: The Eighth Revision of ICD (New Revised Code) is used beginning with January 1969. Comparison with statisties eompiled under the former Code (Seventh Revision ICD) and rates eannot be made. Direet to the Alabama Bureau of Vital Statisties any question about comparability of statisties eompiled and rates under the new vs. the former ICD.

Miami Beach 'Country Doctor'

Joseph D. Kearn, M. D., native New Yorker with his degree in medicine from Edinburgh, Scotland, died in Miami at the age of 56. The following excerpt from a biographical sketch by John Harrington Tanous, M. D., published in *The Bulletin,* Dade County Medical Association, evidences his contribution to the best image of Medicine:

". . . He served from 1942 to 1946 as a Battalion Surgeon with the 504th Air Division. He suffered a compound fracture of his leg during this service, which plagued him continuously during his later years.

"Dr. Joe represented the old fashioned country doctor, even though he practiced on Miami Beach. He never refused to make house calls whether day or night, even after he had his first cerebral accident and had difficulty in walking. I can recall occasions when he would make a house call in the middle of the night, and when a surgical diagnosis was established, would come to the hospital with the patient and stay with the patient during the surgical procedure. He was a conscientious, dedicated physician and his patients idolized him.

"During his long illness and vascular procedures, he had the patience of Job and the tranquility of a man who had served his profession well. When Dr. Joe passed away on July 16, 1969, all humanity lost a tremendously wonderful and compassionate being, and I lost a good friend."

BUREAU OF VITAL STATISTICS

PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA

Ralph W. Roberts, M. S., Director

JULY 1969

Live Births / Deaths / Causes of Death	Number Recorded During July, 1969			Rates* (Annual Basis)		
	Total	White	Non-White	1969	1968	1967
Live Births	5,362	3,616	1,746	17.3	18.1	18.3
Deaths	2,878	1,916	962	9.3	8.8	8.6
Fetal Deaths	95	53	42	17.4	18.9	17.7
Infant Deaths—						
under one month	88	52	36	16.4	19.4	21.1
under one year	113	62	51	21.1	25.2	27.4
Maternal Deaths						5.3
Causes of Death						
Bacillary dysentery, amebiasis, 004, 006	1		1	0.3	0.3	
Enteritis, other diarrheal diseases, 008, 009	2	1	1	0.6	†	†
Tuberculosis, all forms, 010-019	16	6	10	5.2	6.9	5.3
Diphtheria, 032						
Whooping Cough, 033						
Meningococcal infections, 036					0.3	
Poliomyelitis (acute), 040-043**						
Measles, 055	1	1		0.3		
Syphilis, 090-097	3	1	2	1.0	1.0	1.0
Malignant Neoplasms, 140-209	429	323	106	138.6	129.1	121.3
Diabetes Mellitus, 250	66	40	26	21.3	20.3	13.9
Major casdiovascular diseases, 390-448	1,434	972	462	463.2	†	†
Diseases of heart, 390-398, 402, 404, 410-429	960	697	263	310.1	279.1	277.3
Rheumatic fever & heart, 390-398	9	8	1	2.9	†	†
Hypertensive heart & renal diseases, 402, 404	30	14	16	9.7	†	†
Ischemic heart disease, 410-414	829	621	208	267.8	†	†
Cerebrovascular disease, 430-438	393	233	160	126.9	124.2	110.4
Diseases of the arteries, 440-448	63	35	28	20.3	22.3	28.8
Influenza, 470-474	1	1		0.3	0.3	
Pneumonia, 480-486	74	54	20	23.9	15.1	17.8
Bronchitis, emphysema, asthma, 490-493	33	25	8	10.7	†	†
Appendicitis, 540-543	2	1	1	0.6	1.0	1.0
Hernia, intestinal obstr., 550-553, 560	10	6	4	3.2	3.9	3.6
Cirrhosis of liver, 571	14	11	3	4.5	5.6	5.6
Complications of preg., childbirth, 630-678						5.3
Congenital anomalies, 740-759	23	17	6	4.3	6.3	4.0
Immaturity, 777	21	10	11	3.9	4.7	4.0
Accidents, total, 800-949	207	146	61	66.9	73.4	68.1
Motor vehicle accidents, 810-823, 940	121	86	35	39.1	38.7	34.4
All other defined causes	340	208	132	109.8	138.2	137.5
Symptoms & ill-defined, 780-796	201	93	108	64.9	39.0	44.0

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

**Does not include late effects

†NOTE: The Eighth Revision of ICD (New Revised Code) is used beginning with January 1969. Comparison with statistics compiled under the former Code (Seventh Revision ICD) and rates cannot be made. Direct to the Alabama Bureau of Vital Statistics any question about comparability of statistics compiled and rates under the new vs. the former ICD.

Wheelchair Curb-Climber

A curb-climbing wheel chair is presently being tested by the Veterans Administration. The inventor, H. Franklin Coffey, M. D., an orthopedic specialist, described the device at the American Congress of Rehabilitation Medicine, pointing out that the chair can successfully negotiate a 10-inch curb, dropping off the curb on one side, cross a three-lane street, and climb the curb on the other side in 45 seconds.

These aids—a backdrop dolly and "curb-climbers"—permit one to drop safely off a 15-inch curb, backwards, and to raise the wheelchair with only 30 to 40 pounds of force. The devices, with a combined cost of $125, can be attached to most wheelchairs in 45 minutes. They weigh only 13 pounds and do not interfere with folding the wheelchair.

They are described in the Sept. 1 issue of *JAMA*.

* * *

"Psychoanalysis is vanishing," says the Rhode Island Medical Journal, quoting Dr. T. Szasz, an analyst affiliated with Upstate Medical Center in Syracuse, N. Y., and is in fact "in danger of receding into an unimportant sidestream of psychiatry."

Among reasons given for this loss of popular interest in the last 15 years are:

1. Cheaper, quicker therapies that can reach all levels of society are emphasized.

2. Psychoanalysis lacks 'substantial research' and has 'not yet proven effective by Scientific test.'

3. Psychoanalysis hasn't kept pace with the growth of psychiatry.

4. Since no major contributions or discoveries have been made in recent years, psychoanalysis is 'no longer a frontier.'

5. Psychoanalysis suffers from 'a lack of research.'

6. Psychoanalysis has lost its 'capacity to grow.'

7. Psychoanalysis is a 'tightly controlled shop' and has 'little room for doubters or critics.'

8. Psychoanalysis is not usually found in a university context.

9. Psychoanalysis is depicted as a 'rigidly dogmatic and defensive guild, not plugged into the major intellectual currents of the day.'

BUREAU OF PREVENTABLE DISEASES

Frederick S. Wolf, M. D., Director

Current Morbidity Statistics

1969

	August	Sept.	*E. E. Sept.
Tuberculosis	154	92	92
Syphilis	48	51	111
Gonorrhea	688	501	389
Chancroid	0	0	2
Typhoid fever	1	3	1
Salmonella	41	46	14
Undulant fever	0	0	0
Shigella	7	20	13
Amebic dysentery	0	0	4
Scarlet fever & strep. throat	351	480	224
Diphtheria	0	2	2
Whooping cough	4	6	14
Meningitis	23	4	6
Tularemia	0	0	0
Tetanus	2	1	1
Poliomyelitis	1	0	0
Encephalitis	2	0	0
Smallpox	0	0	0
Measles	0	2	12
German measles	6	3	2
Chickenpox	2	7	2
Mumps	15	9	11
Infectious hepatitis	21	21	39
Typhus fever	0	0	0
Malaria	8	5	0
Cancer	1,347	910	646
Pellagra	0	0	0
Rheumatic fever	10	5	12
Rheumatic heart	14	14	24
Influenza	24	66	25
Pneumonia	214	185	141
Rabies—Human cases	0	0	0
Pos. animal heads	9	0	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

PSYCHIATRISTS OR GENERAL PRACTITIONERS

interested in psychiatry. Veterans Administration Hospital, Tuscaloosa, Alabama. Salaries to $19,900 based on training and experience. Liberal retirement plan, 30 days vacation with pay, 15 days sick leave per year, health and life insurance programs. Opportunity for physicians interested in regular hours with less demanding duties than private practice.

Write

CHIEF OF STAFF (11)

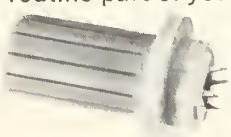
VA Hospital

Tuscaloosa, Alabama 35401

An Equal Opportunity Employer

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site at highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9

PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. MASA members having knowledge of practice opportunities or wishing to relocate their own practices are urged to communicate with the Placement Service. For further information: write Mr. Emmett Wyatt, Executive Assistant, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama 36104, or Telephone 263-6441.

Locations Wanted

General Practice—

Age 33, Medical College of Georgia 1968, seeking parttime employment on weekends and holidays relieving a general practitioner or emergency room duties in south Alabama within reasonable commuting distance of Pensacola, Fla. LW-1

Age 38; University of Oklahoma, 1955; seeking associate, institutional or industrial practice; in town of 10,000 plus population; interest in surgery. LW-5

Age 28; University of Tennessee, 1965. LW-7

Age 27, Medical College of South Carolina, 1966; seeking location in Gadsden area or in southern part of state in town of 5-7,000 population; available July 1, 1971. LW-7/1

Age 60, University of Arkansas 1932, seeking location for general or industrial practice. Available May 1969. LW-7/3

Age 42; Medical College of Alabama 1957; seeking location in central Alabama, near Montgomery. LW-7/4

Age 34; University of Tennessee 1964; seeking associate practice. LW-7/5

Internal Medicine—

Age 59, Cornell University 1933, American Board certified, seeking group practice. LW-8

Age 31, Medical College of South Carolina 1964, Available July 1970. LW-9

Age 37, Duke University, 1956; Board certified, seeking group, associate, or institutional practice. LW-13

Age 33; University of Miami 1962; Board eligible; National Board; seeking solo, group practice, hospital practice, or industrial practice. Available July 1969. LW-13/1

Age 31; Medical College of Georgia 1963; seeking location for practice of internal medicine-cardiology. Available 1970. LW-13/2

Neurology—

Age 32, Medical College of Georgia, 1964, seeking assistant or associate, or institutional practice. LW-14

Age 31; Harvard 1962; Board eligible; National Board; seeking solo, group or associate practice. Available July 1969. LW-15

Age 29, Indiana Univ., 1964; Board eligible; seeking assistant or associate practice in city of over 100,000 population; available July 1, 1969. LW-17/1

Obstetrics-Gynecology—

Age 49, University of Nebraska, 1943; Board certified, seeking group or institutional practice. LW-19

Age 34, Medical College of Virginia, 1961, Board eligible, seeking group or associate practice. LW-20

Age 33; University of Illinois, 1964; seeking associate practice. LW-21

Ophthalmology—

Age 33; St. Louis University, 1962; seeking solo, or associate practice; available July 1, 1969. LW-21/1

Otolaryngology—

Age 32, University of Pennsylvania 1962, seeking associate practice. Available April 1970. LW-21/2

Pathology

Age 32, University of Louisville 1966, seeking associate or institutional practice. Available July 1970. LW-21/4

Radiology

Age 28; Northwestern University 1964; completing radiology residency. Available July 1971. LW-24

Age 43; Louisiana State University 1953; Board certified, seeking associate practice, preferably in southern section of state. Available January 1970. LW-24/1

Surgery—

Age 33; University of Missouri, 1961; seeking group or associate practice. Available January 1969. LW-27

Age 38; Emory University, 1956; Board eligible, seeking group, associate, or institutional practice. LW-28

Age 36, Indiana University 1961; Board eligible; seeking practice in city of 100,000 plus population. Available July 1969. LW-31/1

Age 37, University of Paris 1961; seeking group or institutional practice in city of 80,000 plus population. Available July 1969. LW-31/2

Age 48; Marquette University 1943; Board eligible; seeking institutional practice in east Alabama. Available July 1969. LW-31/3

Age 31; St. Louis University 1963, American Board certified; seeking associate practice. LW-31/3

Age 48; University of Pennsylvania 1950; Board eligible; seeking solo or group practice. LW-31/4

Age 31; Medical College of Alabama 1963; American Board certified; seeking associate practice. Available July 1970. LW-31/4

(Continued on Page 517)



Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Dimetapp Extentabs®

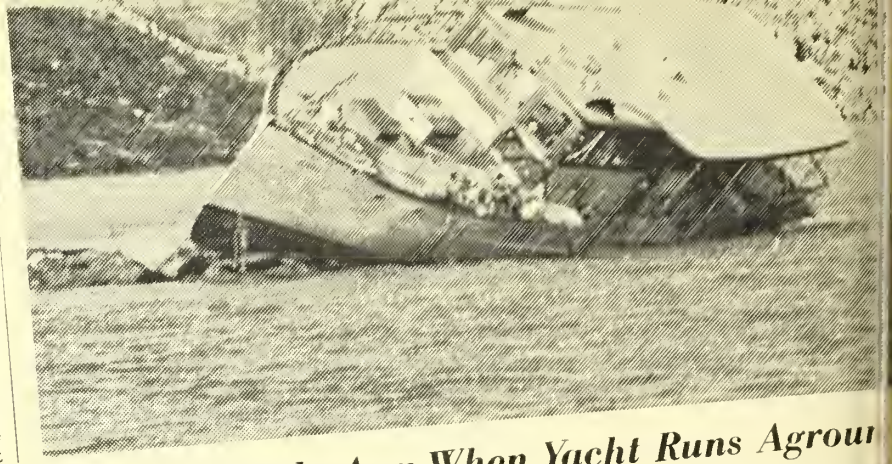
Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS



Owner Breaks Arm When Yacht Runs Agroun

Schuyler, Oct. 31. Harry Waters of Covesville incurred a fractured arm [illegible] acht [illegible] ck a large rock tially capsized. The fire depa had to rescue Waters by sma Damage to the yacht is estim

Hasn't the skipper had enough excitement for one day?

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

A. H. Robins Company, Richmond, Va. 23220 A·H·ROBINS

Phenaphen® with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming)

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.



Locations Wanted

(Continued from Page 514)

Age 36, Emory University 1959, Board certified, seeking associate practice. Available September 1970. LW-31/5

Urology—

Age 30; Louisiana State University, 1963; Board eligible, seeking associate, or group practice. LW-32

Age 31, Chicago Medical School 1963, seeking associate practice in Montgomery. Available July 1970. LW-32/1

Age 32, Albany Medical College 1962, Board eligible, seeking associate practice. Available July 1970. LW-32/2

Student Health—

Age 40, University of Oklahoma 1955, seeking institutional practice. LW-33

Physicians Wanted

Special Openings—

General surgeon, Board certified, needs young associate to do general practice including obstetrics. Salary negotiable. PW-19

Specialist in the following fields: Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practitioners. 58-bed fully accredited general hospital with 91-bed addition recently completed. Modern new office space available. PW-20

Pediatrician, Internist, and ENT specialist to join a well-established group practice in a community of 40,000 in East Alabama. The community has a 125-bed accredited hospital, 32-bed extended care facility. Good transportation on interstate with quick access to metropolitan area. Will pay travel expense for interview. PW-20-1

Opportunity for ENT, Internal Medicine, and Orthopedic Surgery practitioners to join partnership at clinic located in city of 38,000 population in trade area of 150,000 population in northeast Alabama. PW-20/2

Position for full-time industrial practice at textile plant with 2,400 employees at Decatur, Alabama. PW-20/3

Internists, Board-certified or eligible. One needed now and another in 1 or 2 years. For early partnership with internist in south Alabama city of 40,000 plus population. New office building adjacent to 181-bed hospital. Practice largely hospital in-patient and Cardiology. PW-21

Opportunity for a Board certified or eligible surgeon to be associated with a Board surgeon in city of 150,000 population. PW-21/1

The Alabama Department of Mental Health is seeking several physicians. Vacancies exist at Bryce Hospital, Tuscaloosa, and Searcy Hospital, Mt. Vernon. PW-22

General Practitioner or Internist for associate or separate practice in Birmingham. Modern office space and excellent hospital facilities. PW-26

Obstetrician-Gynecologist—

Excellent opportunity for a trained Ob-Gyn man, who would join a two-man partnership in city of 30,000 population located in south central Alabama. Salary is proposed for the first year, with partnership thereafter. PW-25

General Practitioners—

Opportunity for GP to join well established four-man partnership; three general practitioners and one board certified surgeon. Practice located in city of 8,000 population, trade area of 60,000, north-central Alabama. Modern new partnership-owned offices adjacent to modern 125-bed fully accredited hospital. Salaried first year with possible partnership status at end of first year. PW-27

Opportunity in town of 4,000 population in trade area of 50,000 population, located within 100 miles of two metropolitan areas in south Alabama. Industrial and farming area. 44-bed hospital. Office space and equipment available in new building with another physician. Several churches, schools, and service clubs. PW-1

For community of 1,500 population located in south Alabama near city of 12,000 population. Hospitals located within 25 miles. Office space and equipment available. Farming, cattle and textile industries in the area. Several churches and school. Civic clubs and golf courses. PW-1-1

For town of 10,000 population in county of 40,000 population located in scenic mountainous section of Northeast Alabama. Office space and equipment available. Hill-Burton hospital-nursing home. Expanding industries in top agricultural area. PW-1-2

For community of 2,000 population, plus large trade area, located in Southeast Alabama. Modern clinic, fully equipped. PW-1-3

Opportunity in port town of 1,000 plus population in population center of 10,000 located in Southeast Alabama. Clinic available. Hospital located less than 20 miles away. Recreational advantages for water sports. Expanding industrial and farming area. Churches and schools. PW-1-4

For town of approximately 1,000 population in Northwest Alabama, near Tennessee Valley waterways. New 15-bed clinic available. Centrally located near metropolitan areas. Extensive industrial developments. PW-1-5

For town of 12,500 population in trade area of 50,000 located in South Alabama. Nearest large city with population of 145,000 is 80 miles away. Two hospitals with 140 beds. Numerous small industries. Several churches and schools. Recreational activities include water sports and golf course. PW-1-6

(Continued on Page 518)

Physicians Wanted

(Continued from Page 517)

General Practitioner to join partnership in town of 3,000 population, plus trade area of 20,000 population in northwest Alabama. Modern office building with six examining rooms. Full partnership at beginning of third year. New 30-bed Hill-Burton hospital. Salary open. PW-1/7

Opportunity in community of 3,000 population with over 8,000 population in trade area, near metropolitan area in northwest Alabama. Clinic and office equipment available. New 400-bed hospital and older hospital, and several nursing homes. PW-1/8

For town of 2,000 population in trade area of 7,000 population located in west Alabama. Physician recently died. Nearest city is 30 miles away. Medical facilities include Hill-Burton hospital and nursing home. Churches, schools, civic clubs, and recreational advantages. PW-1/9

For town of 1,800 population located in southeast Alabama in a population center of 10,000 population. PW-1/10

For town of 7,000 population located in population center of 15,000 population located in northeast Alabama. Office space and equipment available. Hospitals located in adjoining towns within 12 miles. State University located in the town. PW-1/11

For town of 2,500 population located in northeast Alabama. 17-room modern brick clinic fully equipped. Hospital nearby. Excellent schools and recreational advantages, water sports. PW-1/12

For town of 5,000 population, located in northwest Alabama. 55-bed hospital being completely renovated, and an adjoining 69-bed nursing home. PW-1/13

Opportunity in well situated central Alabama county, trade area of 18,000 population, manufacturing, mining, farming region. New office building furnished. 33-bed accredited hospital. Excellent recreational facilities including new country club. PW-1/14

Opportunity for group practice in town of 10,000 population in north Alabama. PW-2

Physician wanted to join 39 year old Medical College of Alabama graduate in a well established general practice in West Central Alabama town. Salary initially followed soon by full partnership. PW-3

Physician wanted to join well established partnership in Northwest Alabama city of 15,000 population. Two accredited hospitals, junior college, schools, churches, recreational activities. No obstetrics or surgery. New office building. PW-7

For city of approximately 15,000 population in north Alabama, with trade area of approximately 45,000 population. Hospital with over 100 beds, and expansion planned for next year. Nursing homes in the area. Industrial growth and agricultural region. Several churches and schools. Golf course, civic and fraternal organizations. PW-8

For city of 5,000 population located 80 miles northwest of Birmingham. Industrial area. JCAH certified hospital facilities of 70 beds. Office space available for $200 per month. Guaranteed income. One physician in city desires partner, no investment, or associate. PW-1/15

For community of 2,000 population located in central Alabama, 30 miles southeast of Birmingham. Farming area. Clinic available. PW-1/16

For town of 3,600 population in trade area of 5,000-7,000 within 100 miles of two large cities and the Gulf Coast. 50-bed hospital located in the town. Office space available. Agricultural and expanding industrial area. Several churches and two schools. Recreational activities in the town as well as nearby—golf course, hunting and fishing. PW-17

Unusual opportunity for two general practitioners with military obligations satisfied at a modern fifty bed facility located 15 minutes drive from largest metropolitan center in north-central Alabama. Construction of a new two-story office building is scheduled to begin soon. PW-18

Opportunity in city of 5,000 population located in Northeast Alabama in trade area of approximately 10,000 population. Office space available. One physician died recently. Hospital and nursing home in the city. PW-19

Hospital based professional association in suburb of Birmingham is seeking a young general practitioner who has completed military obligation. High income, profit sharing, paid vacation and retirement plan. Complete facilities available. No investment required. PW-19/1

"anorectal disorders"



This Rectopath Model
may help you explain certain anorectal disorders to some of your patients. It is yours on request.

See next page for details.

"anorectal disorder"

includes a range of problems. For symptomatic relief in some of these disorders consider a member of the Anusol Family...

One suppository morning and evening and after each bowel movement.

ANUSOL®

soothing, palliative relief of minor pain, itching, burning, and other associated discomforts.

Each ANUSOL suppository contains bismuth subgallate (2.25%), bismuth resorcin compound (1.75%), benzyl benzoate (1.2%), Peruvian balsam (1.8%), zinc oxide (11.0%), and boric acid (5.0%), plus the following inactive ingredients: bismuth subiodide, calcium phosphate, hydrogenated vegetable oil, and coloring in a cacao butter and white wax base.

One suppository morning and evening for 3 to 5 days.

ANUSOL-HC®

prompt reduction of inflammation plus the soothing effects of regular Anusol.

Each ANUSOL-HC suppository contains, in addition to the regular Anusol formula, 10 mg. hydrocortisone acetate.

Precautions: Prolonged use of Anusol-HC might produce systemic corticosteroid effects.

One suppository every 3 to 4 hours, or every 2 hours if symptoms are severe.

ANUGESIC®

when severe pain requires prompt relief, pramoxine HCl plus the soothing Anusol formula.

Each ANUGESIC suppository contains: 61 mg. bismuth subgallate, 47 mg. bismuth resorcin compound, 32.4 mg. benzyl benzoate, 48.6 mg. Peruvian balsam, 300 mg. zinc oxide, 135 mg. boric acid, and 25 mg. pramoxine hydrochloride. Also contains the following inactive ingredients: bismuth subiodide, calcium phosphate, white wax, benzoinated lard, hydrogenated vegetable oil, and certified coloring in a cacao butter base.

Precautions: If idiosyncratic reaction occurs, discontinue medication.
Symptomatic treatment should not be allowed to delay definitive diagnosis and therapy.

Also available: ANUSOL® OINTMENT AND ANUGESIC® OINTMENT



The Rectopath Model is available from your Warner-Chilcott representative or upon request from Warner-Chilcott Labs., Morris Plains, New Jersey 07950.

Warner-Chilcott Laboratories, Morris Plains, N. J.

N-91-4C

Blue Shield's new URC program incorporates the medical profession's freedom to set fees into a marketable program of prepaid health coverage.

BLUE CROSS-BLUE SHIELD OF ALABAMA ®



INDEX TO ADVERTISERS

Arch Laboratories 436
Blue Cross-Blue Shield 521
The Bradley Center 457
Bristol Laboratories 472
Burroughs Wellcome 427

Campbell Soup 469

Geigy Pharmaceuticals 430, 431, 446, 447, 479, 480, 481, 488
Guest House Motel 491

Highland Hospital 522
Hoechst Pharmaceuticals 435
Hynson, Westcott & Dunning 423

Lederle Laboratories 425, 490, 494, 495, 498, 513
Eli Lilly & Co. ..... 1st Cover, 458

Merck Sharp & Dohme 442, 443, 444
McNeil Laboratories 449
Wm. S. Merrell Co. ..... 3rd Cover

National Drug Co. ..... 2nd Cover, 439, 440

Parke Davis & Co. 452, 506
Pfizer Laboratories 450, 451
Wm. P. Poythress 493

Riker Laboratories 454, 455, 500, 501
A. H. Robins Co., Inc. 505, 509, 515, 516
Roche Laboratories ..... 428, 429, 4th Cover

G. D. Searle Co. 470, 471
Smith, Kline & French 433
Strasenburgh Laboratories 496

Warner Chilcott 483, 484, 519, 520
Wyeth Laboratories 475, 476

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: MRS. ELIZABETH HARKINS, ACSW, *Coordinator of Admissions* or

CHARLES W. NEVILLE, JR., M. D., *Assistant Professor of Psychiatry and Medical Director*

Area Code 704 - 254-3201

Can one prescription do the work of two?



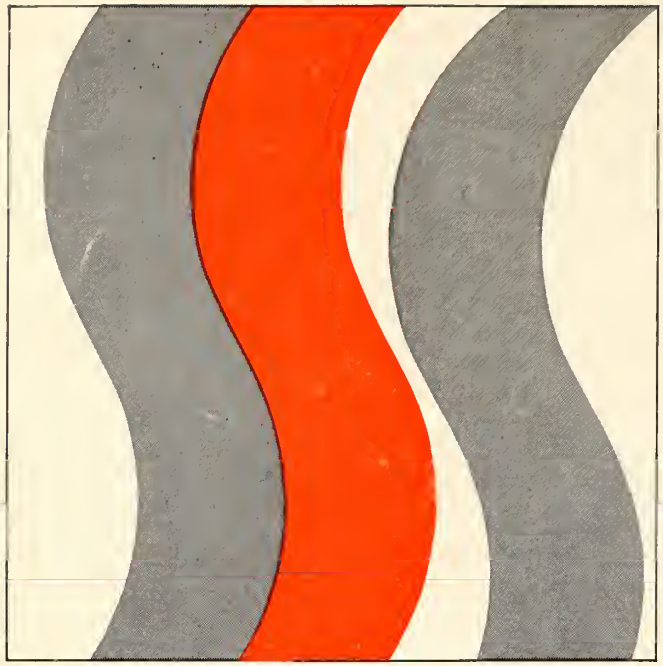
Yes, Kolantyl®.

Kolantyl Gel/Wafers contain antacids, and Bentyl® (dicyclomine hydrochloride) too.

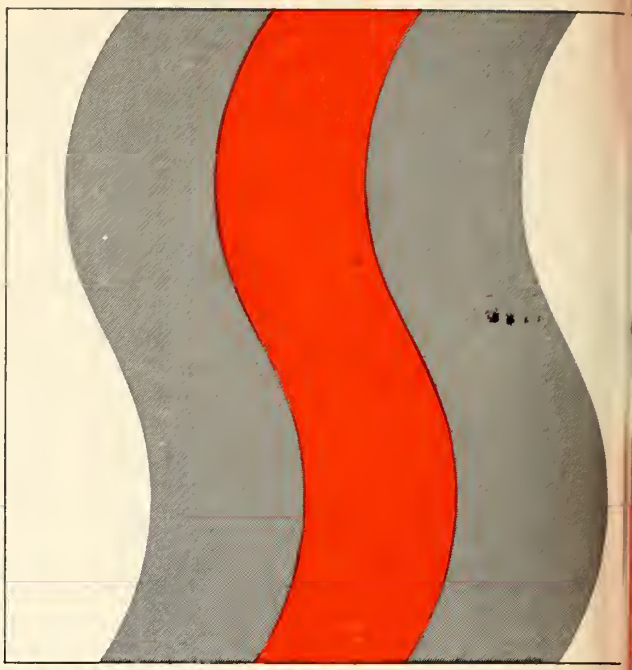
Merrell

The Wm. S. Merrell Company
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215

(0715)



from the discord of anxiety...



to emotional harmony

with the aid of antianxiety

Librium®
(chlordiazepoxide HCl)

5-mg, 10-mg and 25-mg capsules

In an age of swift change and challenge, susceptible individuals may experience varying degrees of excessive anxiety. The resulting emotional stress may precipitate significant functional disorders or complicate existing organic disease. In properly individualized maintenance dosage, Librium (chlordiazepoxide HCl) quickly helps relieve anxiety and apprehension, provides useful adjunctive therapy in psychophysiologic disorders—yet seldom impairs mental acuity or ability to function. Librium has demonstrated a wide margin of safety in short- and long-term therapy.

Also available:

Libritabs®
(chlordiazepoxide)

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, please consult complete product information, o summary of which follows:

Indications: Indicoted when anxiety, tension ond apprehension ore significont components of the clinicol profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Coution potients obout possible combined effects with alcohol ond other CNS depressants. As with oll CNS-octing drugs, caution potients against hazordous occupations requiring complete mental alertness (e.g., operating mochinery, driving). Though physical and psychologicol dependence hove rorely been reported on recommended doses, use coutian i odministering to oddiction-prone individuols or those who might increase dosoge; withdrowal symptoms (including convulsions), follawing discantinuotian of the drug ond similar to those seen with barbiturates, have been reported. Use of ony drug in pregnancy, lactation, or in women of childbeoring oge requires that its potential benefits be weighed agains its possible hazards.

Precautions: In the elderly and debilitoted, and in children over six, limit t smollest effective dosage (initially 10 mg or less per day) to preclude atax or aversedatian, increasing grodually as needed and toleroted. Not recommended in children under six. Though generally not recammended, i combinotion theropy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiati drugs such as MAO inhibitors and phenathiazines. Observe usuol precautians in presence of impaired renal or hepatic functian. Parodoxical reoctions (e.g., excitement, stimulotion and acute roge) have been reported in psychiatric patients and hyperoctive oggressive children. Empl usuol precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measur necessary. Voriable effects on blood caagulatian have been reparted very rorely in patients receiving the drug ond aral anticaagulants; causal relationship has not been established clinicolly.

Adverse Reactions: Drowsiness, otoxio and confusion may occur, especial in the elderly ond debilitated. These ore reversible in most instonces by proper dosoge adjustment, but are also occasionally observed at the lawe dosoge ranges. In o few instances syncope has been reparted. Also encountered ore isolated instonces of skin eruptions, edema, minor menstruc irregularities, nauseo ond constipotion, extrapyramidal symptoms, increa and decreosed libido—all infrequent ond generolly controlled with dosag reduction; changes in EEG patterns (low-voltoge fost activity) may appea during and after treatment; blood dyscrasios (including ogronulocytosis), jaundice and hepatic dysfunction have been reported occosianally, makir periodic blood counts and liver function tests advisable during protracted therapy.

JOURNAL of the Medical Association of the State of ALABAMA

...E STATE OF ALABAMA ... 1873 ...
...HELVES
...FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON
23 DEC 1969

IN THIS ISSUE

Specialized Hospital Care of Coronary Artery Disease 551

Pulmonary Function Testing for the General Hospital and Physician 567

Fathers and Sons in Medicine 594

Hobbies to Fill a Doctor's Leisure 603

Write it any way you please

Cordran®

Flurandrenolone



Cream Cordran contains flurandrenolone, 0.05 percent, stearic acid, cetyl alcohol, mineral oil, polyoxyl 40 stearate, ethylparaben, glycerin, and purified water.

Lilly

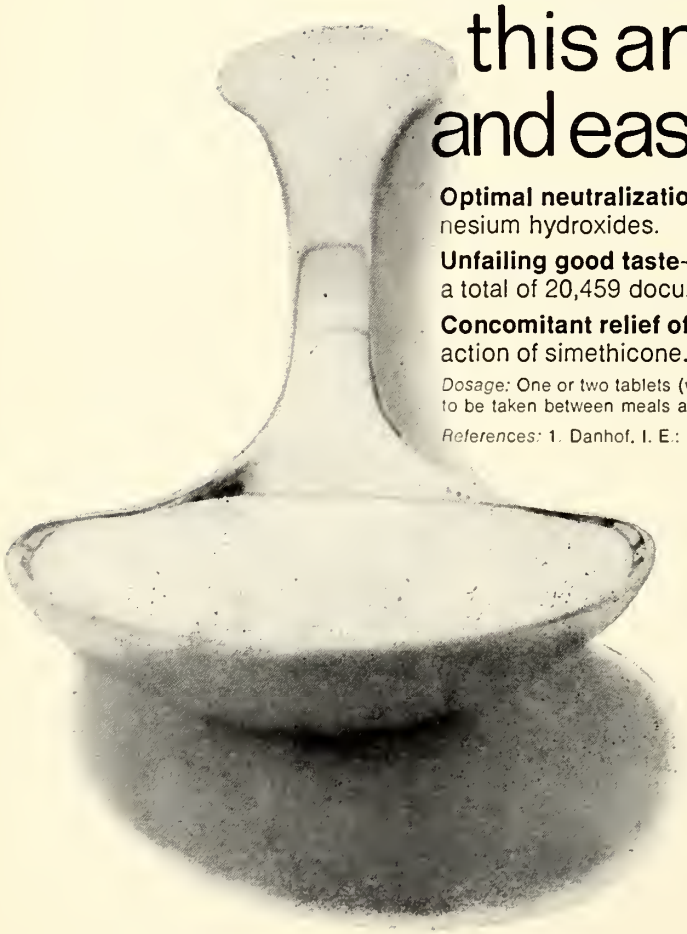
Additional information available upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

...ge Office
Francis A. Countway Lib. of
Medicine
10 Shattuck St.
Boston, Massachusett...

DECEMBER 1969

the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization—provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste—confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[1]

Concomitant relief of G. I. gas distress—provided by the proven antiflatulent action of simethicone.[2]

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References: 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. 93:467 (Sept.) 1966.

Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON
DEC 1969

Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

N THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF
REMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

LUTREXIN, the non-steroid "uterine elaxing factor" has been found to be useful y many clinicians in controlling abnormal terine activity.

Literature on indications and dosage available on request.

- No side effects have been reported, even when massive doses (25 tablets per day) were administered.
- Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. BALTIMORE, MARYLAND 21201

(LTR23)

THE JOURNAL

of the

Medical Association of the State of Alabama

Volume 39 • December, 1969 • No. 6

Office of Publication
19 So. Jackson St. . . Montgomery, Ala. 36104
Subscription Price . . . . . $5.00 Per Year
$1.00 Per Copy

Second Class Postage Paid at Montgomery, Alabama. Published monthly in Montgomery at 19 South Jackson Street.

Editor-in-Chief
William L. Smith, M. D. . . . . Montgomery

Managing Editor
L. P. Patterson . . . . . Montgomery

Assistant Managing Editor
Mary Nell Williford . . . . . Montgomery

Associate Editors
J. P. Collier, M. D. . . . . Tuscaloosa
John M. Chenault, M. D. . . . . Decatur
M. Vaun Adams, M. D. . . . . Mobile

Officers of the Association

President
C. Kermit Pitt, M. D. . . . . Decatur

President-Elect
S. Buford Word, M. D. . . . . Birmingham

Vice-Presidents
F. M. Phillippi, Jr., M. D. . . . . Brewton
J. E. Cameron, M. D. . . . . Alexander City
O. Emfinger, M. D. . . . . Union Springs
Wood S. Herren, M. D. . . . . Birmingham

Secretary-Treasurer
William L. Smith, M. D. . . . . Montgomery

Executive Director
L. P. Patterson . . . . . Montgomery

The State Board of Censors
John M. Chenault, M. D., Chmn. . . . . Decatur
J. P. Collier, M. D. . . . . Tuscaloosa
Hugh E. Gray, M. D. . . . . Anniston
Paul W. Burleson, M. D. . . . . Birmingham
L. L. Hill, M. D. . . . . Montgomery
M. Vaun Adams, M. D. . . . . Mobile
J. D. Bush, M. D. . . . . Gadsden
E. L. Strandell, M. D. . . . . Brewton
John W. Davis, Jr., M. D. . . . . Montgomery
J. Garber Galbraith, M. D. . . . . Birmingham

State Health Officer
Ira L. Myers, M. D. . . . . Montgomery

Delegates and Alternates to the American Medical Association

(Terms expiring December 31 of year shown.)

1970
Delegate—E. Bryce Robinson, Jr., M. D., . Fairfield
Alternate—W. E. White . . . . . Anniston

1971
Delegate—M. Vaun Adams, M. D. . . . . Mobile
Alternate—E. L. McCafferty, Jr., M. D. . . Mobile
Delegate—P. W. Burleson, M. D. . . . . Birmingham
Alternate—Robert Parker, M. D. . . . . Montgomery

CONTENTS

President's Page 526

The Woman's Auxiliary 527

Editorial Comment 529

- Christmas Greetings 529
- A "Posture of Depression" Leads To Self-Destruction 532
- Just Who Is Altering The Benign Face Of Medicine? 536

Alabama Department of Public Health 537

- A Survey To Assess Public Participation In A Rubella Immunization Program In An Alabama County 537

Legal Page: 547

- Physicians Fiscal Profile 547

Scientific Section 551

- Specialized Hospital Care Of Coronary Artery Disease, Charles E. Rackley, M. D., Birmingham 551
- Pulmonary Function Testing For The General Hospital And Physician, D. S. Tysinger, Jr., M. D., Dothan 555

Association Forum 567

- SSA Regulations For Coverage Of Injections 567

The Month In Washington 572

Around The State 579

- New Physicians Licensed To Practice In Alabama 579
- Syphilis In General Retreat Over State Of Alabama 586
- Three Mobile Doctors Develop Brush Biopsy Technique 592

Books Of Interest To Doctors And Patients 593

Fathers And Sons In Medicine 594

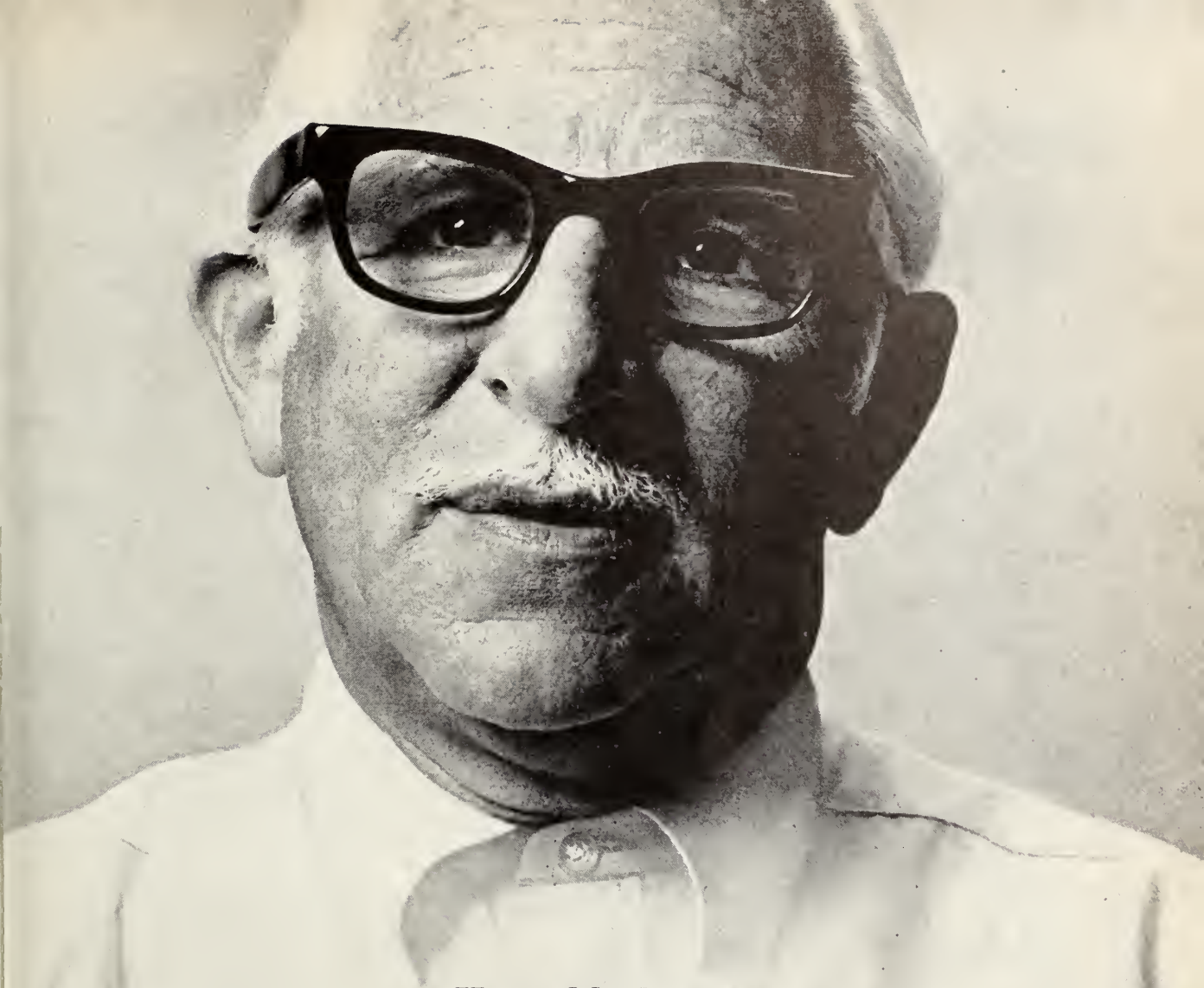
- Six Jordans In Three Generations 594
- Immediate Past MASA President And His Father 596
- Distinguished Anniston Doctor In New Year's 50-Year Club 597

Dr. Craddock Dead At 80 598

Hobbies To Fill A Doctor's Leisure 603

- When The Billfish Leaps From A Hundred Fathoms Deep 603

Physician Placement Service In Alabama 608



He is elderly, he is on corticosteroids, when he needs an antibiotic he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

ıard susceptible patients against intestinal monilial over- th during broad-spectrum therapy—the protection of atin is combined with demethylchlortetracycline in LOSTATIN.

r your susceptible candidates, prescribe DECLOSTATIN broad-spectrum therapy that prevents monilial growth.

aindication: History of hypersensitivity to demethylchlortetracy- or nystatin.

ing: In renal impairment, usual doses may lead to excessive accumu- and liver toxicity. Under such conditions, lower than usual doses dicated, and, if therapy is prolonged, serum level determinations e advisable. A photodynamic reaction to natural or artificial sun- has been observed. Small amounts of drug and short exposure may ce an exaggerated sunburn reaction which may range from ery- to severe skin manifestations. In a smaller proportion, photo- ic reactions have been reported. Patients should avoid direct ure to sunlight and discontinue drug at the first evidence of skin nfort. Necessary subsequent courses of treatment with tetracy- should be carefully observed.

utions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES, A Division of American Cyanamid Company
Pearl River, New York

President's Page

The Holiday Season *comes apace, the* Christmas Season *when we*

Remember old friends who think we have forgotten
Know that it really is better to give than to get
Wish to be better than we are.

The Glad Season *when*

Steps are lighter
Smiles are brighter
Music's sweeter
Love threatens triumph

and when

I appreciate the privilege of this page
to wish for all who read it
and for those they love

Joyful Christmas
and
Happy New Year!

C. Kermit Pitt, M. D.

The Woman's Auxiliary

President, Mrs. Ben H. Johnson, Jr.
President-Elect, Mrs. Howard C. Johnson
Northeast District Vice President, Mrs. James D. Holliman, Jr.
Northwest District Vice President, Mrs. Gene Qualls
Southeast District Vice President, Mrs. George Andrews
Southwest District Vice President, Mrs. Andrew D. Henderson
WAMASA Editor, Mrs. William L. Smith

AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the Medical Association of the State of Alabama. I will support its activities, protect its reputation and ever sustain its high ideals."

I wish to say a special "THANK YOU" to the husbands of the District Vice-Presidents of the Auxiliary for sharing them with us. These girls have sent out hundreds of letters to county presidents, chairmen, and members of the Auxiliaries, and to many others who are not in membership but whom we would like to interest and enlist in our program.

Mrs. Gene Qualls (Nancy) of Sheffield, First Vice-President, Northwest District, is a dedicated Auxiliary member. She has served in many capacities in the state organization and is an inspiration to all of us. Mrs. George Andrews (Jeanette) of Ozark, Second Vice-President, Southeast District, attractive, young, with a great personality, and a real worker. Mrs. Andrew D. Henderson (Helen), of Mobile, Third Vice-President, Southwest District, a charming lady who lives in an equally charming house, hospitable and gracious. And Mrs. James D. Holliman (Nancy) of Huntsville, Fourth Vice-President, Northeast, with great ideas for membership and who made quite a hit at the Regional Conference in Dallas with her enthusiasm and energetic approach to the BIG problem of enlisting new members.

These District Vice-Presidents are responsible for membership in their Districts and also for Members-at-Large. Another responsibility is to plan the District Workshop and to enlist a County Auxiliary to host the meeting. All of these workshops have been very successful this year, so girls take a bow and now bake that doctor husband a good pie for his patience and support of the Auxiliary.

Our membership committee is composed of these District Vice-Presidents and is headed by our President-elect, Mrs. Howard Johnson of Sheffield, membership chairman. In addition she must attend all conferences and many county meetings and is all the time helping the president with the many duties that come our way. Camille is as energetic as her devastating namesake, and we all look out when Hurricane Camille comes sweeping our way.



Mrs. Ben H. Johnson

Now, how would you like to play Santa Claus to the Auxiliary? There is a doctor in Fort Payne, whose wife is a past state president, who gives $100 to the AMA-ERF Auxiliary Fund every year at Christmas, to be credited to DeKalb county. What a boost for these girls who raise money in $5 and $10

contributions, and it takes so many of these to make up our quota for AMA-ERF. There is a doctor in Marshall County who sends many memorials every year and another in Shelby County. There are many doctors, throughout the state who give $100 donations to the medical school of their choice, or to the Loan Fund, and Calhoun County gives generously to the Biomedical Research Laboratory.

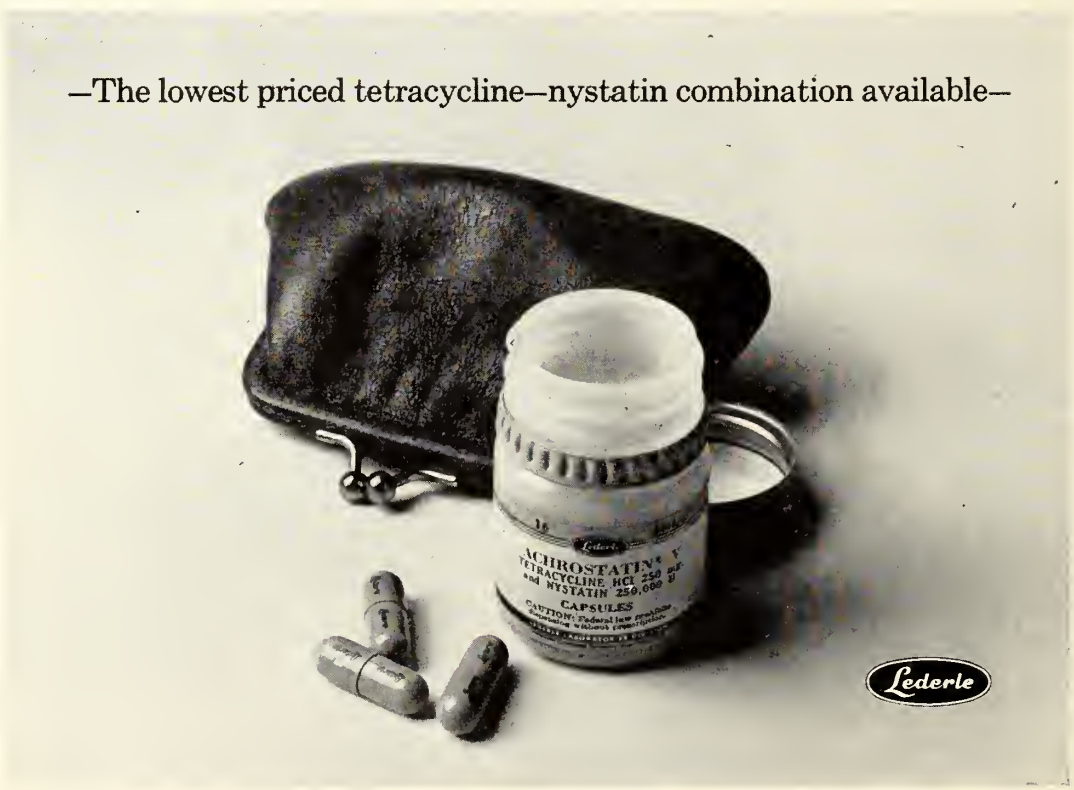
Since the trustees of the Medical Society have allowed the Auxiliary to take the responsibility of contacting all the doctors in Alabama asking for contributions, income tax deductible, you will have received by now a letter from Mrs. Richard A. Dillard, AMA-ERF Chairman, giving all the details of the program. You may also give us credit for your Alumni contributions to your Alma Mater if the check is made out to the AMA-ERF Auxiliary Fund and designated for that particular Medical School.

And another reminder, ALAPAC and AMPAC dues are to be paid in January, so get in a generous mood, be carried away by the Christmas spirit and send checks right away for

Christmas is 'a comin' and the geese are
gettin' fat,
Have you got a penny for an old man's hat?
If you haven't got a penny
A ha' penny will do,
And if you haven't got a ha' penny
Then GOD BLESS you.

Ruth L. Johnson

(Mrs. Ben H. Johnson, Jr.)
President, WAMASA





Christmas Greetings

Everyone can be enthusiastic about the day:

However you spell it (C-h-r-i-s-t-m-a-s or X-m-a-s or Y-u-l-e-t-i-d-e), or

However you look at it (as a Catholic or a Protestant, as a Christian or a Jew, as an Idealist or an Idolater, as an Adult or a Juvenile), and

However you observe it (as religious symbolism or as an annual time for revelry).

December 25th was a day of merriment long before the advent of Christianity (and for that reason was outlawed as a pagan observance in the days of Oliver Cromwell). It was appropriated by the Church of the West (Rome) long after the birth of Christ and long before it was adopted by the Church of the East (Constantinople, now Istanbul).

But the spirit of Christmas is the thrill of receiving, the joy of giving, and the basics of happiness. Recognizing happiness as "a state of mind," one must also accept Christmas as the capital of that state.

Today, frustrations crowd the heels of further frustrations. Yesterday's cliches are being contradicted, its convictions discredited, its respected professions profaned, and, to some, the clouds seem lowering on a dying civilization. Tomorrow is a time to look forward to—hopefully or with despair.

Even the gloomiest of us knows that the sun will peep through the clouds on one day this month. That day is Thursday, the 25th.

And so, as is the good custom of every December issue of The Journal of the Medical Association of the State of Alabama, we'll repeat in the immortal words of Clement Clarke Moore's St. Nicholas:

"Happy Christmas to all . . ."

Population Growth Noted

The population of the United States is expected to reach about 205,500,000 by next July, and to exceed 235 million in 1980, according to statistics of Metropolitan Life Insurance Company . . . Since World War II, both the total population and the labor force of the United States, including the armed forces overseas, have shown a substantial growth pattern.

Time Erodes Drug Power

The effectiveness lifetime of individual drugs, determined by exhaustive tests, is being stamped with an expiration date on the products of at least one American pharmaceutical company, Warner-Lambert. This program has just been announced by Glenn Hastings, president of the Warner-Chilcott Laboratories Division, Morris Plains, N. J.

(Continued on Page 532)



When trauma results in pain, try Norgesic first... your patients probably won't need anything stronger

Sprains, strains, fractures... Norgesic offers predictable relief in the great majority of traumatic injuries where both pain and muscle spasm are involved. Unlike "pure" analgesics or muscle relaxants, Norgesic affects both components of musculo-skeletal pain, providing effective analgesia and relief of associated muscle spasm.

Norgesic works quickly, usually producing a high level of analgesia within two hours, and relief is sustained for four hours or longer. Thus, when trauma results in pain, try Norgesic first... your patients probably won't need anything stronger.

Indications: Symptomatic relief of mild to moderate pain of acute musculo-skeletal disorders. Here, Norgesic demonstrated clinical superiority to APC as an analgesic.

Contraindications: Because of the mild anticholinergic effect of orphenadrine, Norgesic should not be used in patients with glaucoma, pyloric or duodenal obstruction, achalasia, prostatic hypertrophy, obstructions at the bladder neck, myasthenia gravis and in patients known to be sensitive to aspirin, phenacetin or caffeine. Do not use propoxyphene (Darvon®) concurrently.

Warnings: USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the childbearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child. USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

Precautions: It has been reported that prolonged or excessive use of phenacetin may result in nephrotoxicity. Caution, therefore, should be exercised when Norgesic is administered to patients with renal disorders.

Adverse Reactions: Side effects of Norgesic are those usually associated with APC or mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, some degree of confusion in the elderly, mild central excitation and occasional hallucinations. These mild side effects are usually eliminated by reduction in dosage. One case of aplastic anemia, with no established causal relationship, has been reported.

Dosage and Administration: Adults—1 to 2 tablets 3 to 4 times daily.

For more detailed prescribing information, see Package Circular or PDR.

Available V.A. Supply Depot—FSN6505-952-6762A



NORGESIC®

(orphenadrine citrate, 25 mg., aspirin, 225 mg., phenacetin, 160 mg., caffeine, 30 mg.)

Riker Laboratories, Northridge, California 91324

Sponsors of Riker Service—
the complimentary classified service for physicians.



You can give a better ear exam EASIER with the new Hotchkiss™ Otoscope

A radical advance in otoscope design, the Hotchkiss employs the principles of modern optics to give you a brighter, clearer, more informative view of the ear canal and tympanic membrane. It weighs just five ounces (including batteries) and fits into your shirt or jacket pocket. You can carry it anywhere; use it repeatedly without fatigue. And the Hotchkiss is built to stand up to far rougher treatment than you're likely to give it.

See for yourself. Clip and mail the coupon, and our Representative will call for an appointment to show you the new Hotchkiss Otoscope in your office.

SK&F **Smith Kline & French Laboratories**

Smith Kline & French Laboratories E-30 A
1500 Spring Garden Street
Philadelphia, Pa. 19101

I would like your Representative to call for an appointment to show me the Hotchkiss Otoscope.

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

☐ Send descriptive literature

A "Posture of Depression" Leads To Self-Destruction

The rising tide of suicide is becoming a growing concern, and instances of early-teenage children taking their own lives serve as exclamation points. One such instance was headlined in Alabama several years ago.

Dr. James Jan-Tausch of the New Jersey Department of Education made a study of 41 student suicides in the New Jersey School system from 1960 to 1963 and came up with the startling evidence that for every successful suicide there are nine unsuccessful attempts. So one might say that statistics may be multiplied by ten. Which may in turn be multiplied by two, if the further findings in the New Jersey survey are valid: that "at least an equal number of deaths classified as accidents are actually suicides."

The current issue of *Massachusetts Physician* quotes a Harvard psychiatrist Mathew Ross, M. D., speaking at a meeting of the American College of Surgeons in Boston, as chiding his colleagues for not doing more to prevent suicides among the college-age group, and listed what he termed danger signals:

1. A "posture of depression" in which the student becomes withdrawn, "seldom leaving his room, which has, like himself, become increasingly unkempt and uncared for." Lack of appetite, headaches, constipation and loss of weight may accompany the condition.

2. A decline in self-esteem, which manfests itself in daydreaming, procrastination in school work, inability to concentrate on reading material, apathy and fatigue.

3. Loss of interest in academic work. "The student may prefer to thumb through magazines, sit about all day listening to hi-fi or just languishing."

Dr. Ross added that suicide threats and notes should be taken seriously, always. And that academic competition, social isolation and hard work "today more than ever, produce severe emotional strain. Physicians should be extremely sensitive to the needs of college-age people."

What factors are responsible for these tragedies? Some psychiatrists, says *Massachusetts Physician,* "point to homosexual panic, separation anxiety, parental pressures and fear of school failure as possible causes. Others blame the general permissiveness of modern society. In the opinion of Paul Friedman, M. D., New York City psychoanalyst, permissiveness destroys rather than strengthens the ego of young people. He points the finger at immaturity, the decline of authority at home and schools, and the prevalence of violence as responsible for some of the youthful suicides."

But the most significant part of the long article was Dr. Jan-Tausch's aside that "a personality profile of the suicidal child" shows he is often found "among those who take no part in school activities outside the classroom."

In other words, watch the child without close friends, who refuses to become involved in the interests of his school and his schoolmates.

(Continued on Page 536)

PSYCHIATRISTS OR GENERAL PRACTITIONERS

interested in psychiatry. Veterans Administration Hospital, Tuscaloosa, Alabama. Salaries to $19,900 based on training and experience. Liberal retirement plan, 30 days vacation with pay, 15 days sick leave per year, health and life insurance programs. Opportunity for physicians interested in regular hours with less demanding duties than private practice.

Write

CHIEF OF STAFF (11)

VA Hospital

Tuscaloosa, Alabama 35401

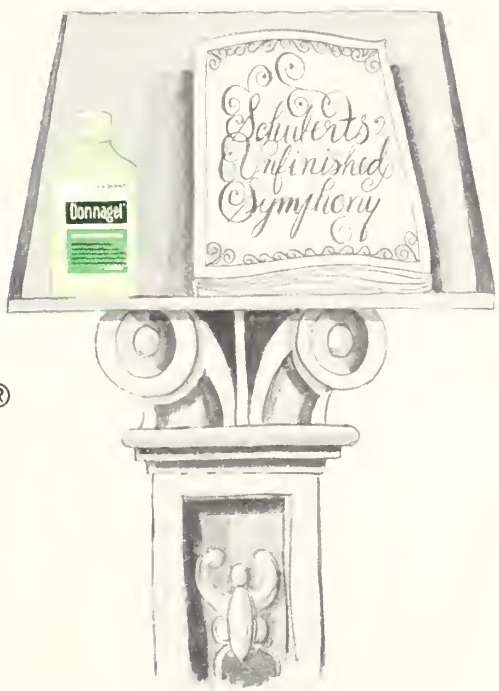
An Equal Opportunity Employer



The concert was just underway,
When to the conductor's dismay
Cramps and diarrhea,
Did so quickly appear,
The maestro no longer could stay.

Because diarrhea with cramping, nausea, and painful straining can
r at the most inopportune time, it takes a comprehensive agent to treat the
a diarrheal syndrome and help get the patient back on the job. That's why
any physicians rely on Donnagel, especially during the fall and winter
hs when "flu" and viral gastroenteritis usually hit their peak.

Donnagel is much more than just a simple kaolin-pectin combination.
so contains the belladonna alkaloids to calm GI hypermotility and help
ve the distressing discomforts which so often accompany diarrhea. Certainly
ess expensive and more convenient than taking two medications. And the
ge is lower too. Available in the handy 4-oz. plastic bottle at pharmacies
where on your prescription or recommendation.



Diarrhea and its Discomforts

Donnagel®

fluid ounce contains: Kaolin, 6 Gm.; Pectin, 142.8 mg.; Hyoscyamine sulfate,
37 mg.; Atropine sulfate, 0.0194 mg.; Hyoscine hydrobromide, 0.0065 mg.;
um benzoate (preservative), 60 mg.; Alcohol, 3.8%.

A.H. ROBINS A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220


PHOTO BY VICTOR HA


Robitussin
Robitussin-DM
Robitussin A-C
Robitussin-PE
4 FL OZ.
A.H. ROBINS
Robitussin-DM
Cough Calmers
Cough Calmers

CLEAR THE TRACT!

THERE'S A ROBITUSSIN FOR EVERY COUGHING NEED

All the Robitussins contain gylceryl guaiacolate, an outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Alcohol, 3.5%

Non-narcotic for 6-8 hr. cough control
ROBITUSSIN-DM®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Dextromethorphan hydrobromide . . . . 15.0 mg.
Alcohol, 1.4%

For unproductive allergic coughs
ROBITUSSIN A-C®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Pheniramine maleate . . 7.5 mg.
Codeine phosphate . . . 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN-PE®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Phenylephrine hydrochloride. . . . . 10.0 mg.
Alcohol, 1.4%

Robitussin-DM in solid form for "coughs on the go"
COUGH CALMERS™
Each Cough Calmer contains:
Glyceryl guaiacolate . . 50.0 mg.
Dextromethorphan hydrobromide . . . . 7.5 mg.

Use this handy guide to pick the right formulation for each coughing need

	Robitussin	Robitussin-DM	Robitussin A-C	Robitussin-PE	Cough Calmers
Expectorant	●	●	●	●	●
Demulcent	●	●	●	●	●
Cough Suppressant		●	●		●
Antihistamine			●		
Long-Acting (6-8 hours)		●			●
Nasal, Sinus Decongestant				●	
Non-narcotic	●	●		●	●

H·ROBINS A. H. Robins Company, Richmond, Va. 23220

Just Who Is Altering The Benign Face of Medicine?

Whether one treats the changing face of medicine *casually* or with *concern* or, like the Irish physician said he treated venereal disease, "with *contimpt*," the fact remains that the face is becoming unrecognizable.

And not only to the oldsters in the profession.

Unlike the human face, which moves from the soft baby complexion of the very young to the weathered roughness of maturity and on to the wrinkled surface of advancing age, a simile for the changing face of medicine may be found in the images on Stone Mountain, where the faces of Confederate leaders have been altered and re-chiseled to suit the whims of sculptors coming after Gutzon Borglum.

Or to some, a more apt simile may be found in Thorn Smith's fantasy of the 1920's, "The Glorious Pool." To tumble into it was to feel the years falling away fast, like reversing a moving picture of life. To overstay was to return to the cradle.

It hasn't been long since grave-robbers were the only source of cadavers. Even more recent is the time when the surgeon had no anesthesia, when the family physician's principal implements were the leech and the purge. And these were still the order of the medical day when Sir Luke S. Fildes, the British artist, was painting that classic canvas of 75 years ago, "The Doctor."

The familiar face of medicine is not like Helen's face, "that launched a thousand ships and burned the topless towers of Ilium." It is more benign than beautiful. Nor is it the face of the witch doctor of Africa or the medicine man of primitive America. Those reflected likenesses are to be found more in the area of the "Christian Scientist," the faith healer, and the chiropractor.

However you look at it, in profile or eyeball-to-eyeball, the famiilar face of medicine is not as famiilar as it used to be. If the changes and alterations are being made by qualified plastic surgeons, there is little to fear. But there is reason to suspect that the surgery is being entrusted to unlicensed, irresponsible and inexperienced experimenters.

Slow Poisons Enveloping Earth

Some years ago Rachel Carson summarized dramatically the proven facts that such substances as DDT and other related compounds are gradually permeating our environment and causing extensive and lasting damage to many varieties of fish, birds, and animals, including man, who in his short-sighted course has tampered ignorantly with his ecology and is reaping the unhappy rewards of his stupidity.

Continuing study shows that these slow poisons are widespread over the earth. They are shown to be extremely harmful to wildlife and domestic creatures. Their value in agriculture appears not to balance with the damage they do, and their subborn resistance to disintegration renders them a very long term menace.

As the result of extensive exposure of evidence against the compounds at a recent important hearing in Wisconsin, the federal Department of Agriculture has suspended—permanently, it is to be hoped—the use of these substances in all federally sponsored programs. This action has come about despite the strenuous efforts of the manufacturers who dispense these poisons. It is to be hoped that the bans will become permanent and worldwide. We have enough to guard against without poisoning ourselves.

—Journal of the South Carolina Medical Association

Alabama Department of Public Health

A Survey To Assess Public Participation In A Rubella Immunization Program In An Alabama County

Philip D. Darney, M. D., and Raymond L. Overton

Introduction

Rubella, or German measles, has long been recognized as a common but relatively unimportant illness of childhood. When adults get the disease, especially women, they may experience self-limited arthralgia or arthritis. The real significance of rubella lies in the teratogenic effects of the rubella virus when it infects a developing fetus during the first trimester of pregnancy. Some of the commonly recognized defects of the congenital rubella syndrome are cataracts, cardiac malformations, deafness, and mental retardation.

Most cases of rubella are in school-age children, more commonly during the winter and spring months. By early adulthood approximately 80 to 90 per cent of individuals in the United States have serological evidence of immunity.[1] Epidemics of rubella seem to occur each six to nine years. During the last severe epidemic in 1964, estimates indicate that 20,000 to 30,000 infants were born with severe congenital anomalies.[2] These tragic consequences of maternal rubella stimulated research which culminated in the development of a live, attenuated rubella virus vaccine. The vaccine was licensed on June 9, 1969, and was reported by the U. S. Public Health Service to be "a highly effective immunizing agent and the first suitable method of controlling rubella."[2]

The availability of a safe, effective vaccine stimulated the State of Alabama Department of Public Health to contemplate widespread immunization of Alabama's 700,000 children* of one through nine years of age. The need for a rubella immunization program in Alabama was demonstrated when serological testing by the Alabama State Laboratories using the hemagglutination inhibition (HI) technique revealed that about twelve per cent of women of childbearing age in Alabama were susceptible to rubella infection.[3] This percentage of susceptibles correlates well with similar studies done elsewhere and, when applied to 1960 census data, indicates that about 80,000 women in Alabama run the risk of rubella infection during pregnancy.

Control of rubella depends on widespread immunization of children, who represent the major reservoir of the susceptible population responsible for spread of rubella to pregnant women. It is, of course, not possible to immunize the women themselves because of the risk that infection with the vaccine virus may have teratogenic effects in the fetus. In order to achieve this widespread immunity, parents must be persuaded to bring their children to a physician or clinic for vaccination. The Alabama Department of Public Health was concerned that a rubella immunization program might not win public acceptance as broad as that achieved with polio and, more recently, measles immunization programs, since the principal objective of rubella vacci-

* All population figures are based on 1960 census data.

nation is to obtain community, rather than individual, immunity. Would a parent agree to have his child vaccinated in order to protect not the child himself but the pregnant women of the community? In order to assess public acceptance of rubella vaccine and devise efficient methods for its administration, the Alabama Department of Public Health decided to carry out a preliminary rubella immunization program in a single Alabama county.

Methods

On the basis of population and geographical characteristics, a county in Southeastern Alabama was selected for the study. School enrollment of children aged five and nine totaled 2,058, and live birth data indicated that there were 1,650 children aged one through four in the county, making a total of about 3,708 children eligible for immunization under the guidelines adopted by the Alabama Department of Public Health.

Requests for permission to immunize against rubella were distributed to all school children at both public and private schools throughout the county. The children took the permission slips home to their parents who were asked to grant permission for their child to be immunized at school by signing the slip and returning it to school the next day. The explanatory paragraphs of the permission slip, which are reproduced below, also invited parents to bring their preschool children to immunization clinics.

Dear Parent or Guardian:

In order to prevent rubella (German measles) from occurring in your child's school and in the community, the Barbour County Health Department is offering *FREE* rubella vaccine *to all children from ages 1 through 9.* All you need do for your child to receive the vaccine is complete the form below, sign it, and have your child return it to the teacher tomorrow. If you have children who do not yet go to school, you may bring them to any of the following scheduled clinics, including the special health department night clinics, for a free rubella vaccination.

Rubella, sometimes called German measles or 3-day measles, is a virus infection which can cause a baby to be born blind, deaf, mentally retarded, with a bad heart, or with a combination of these and other abnormal conditions. Rubella can cause a baby to have these things wrong with him only if his mother has the infection during the first three months that she is pregnant with the baby.

In order to keep babies from being born with defects caused by rubella virus infecting their mothers, we must keep their mothers from catching the infection from children. Expectant mothers who have not already had rubella almost always catch it from children who are 1 through 9 years old. If we give rubella vaccine to all 1 through 9 year old children, we can stop the rubella virus from being passed to expectant mothers and causing the birth of blind, retarded, deaf, and deformed babies.

The permission slips were distributed by teachers two weeks in advance of immunization clinics to allow adequate time for interviewing each parent who failed to have his child return the slip to school. If after five days the permission slip had not yet been returned, an Immunization Project field worker telephoned or visited the parent and asked why the slip had not been returned. The interviewer recorded the parent's response and, if the parent seemed interested in the immunization program, offered a second permission slip. In order to make parents who had no children of school age aware of the rubella immunization campaign, extensive radio and newspaper announcements publicized the clinic times and locations. In addition, Office of Economic Opportunity workers made house-to-house calls throughout the county, giving residents information about rubella and the immunization clinics.

Table 1: PARENTS' REASONS FOR FAILURE TO RETURN PERMISSION SLIP FOR BARBOUR COUNTY SCHOOLS' RUBELLA VACCINATION PROGRAM

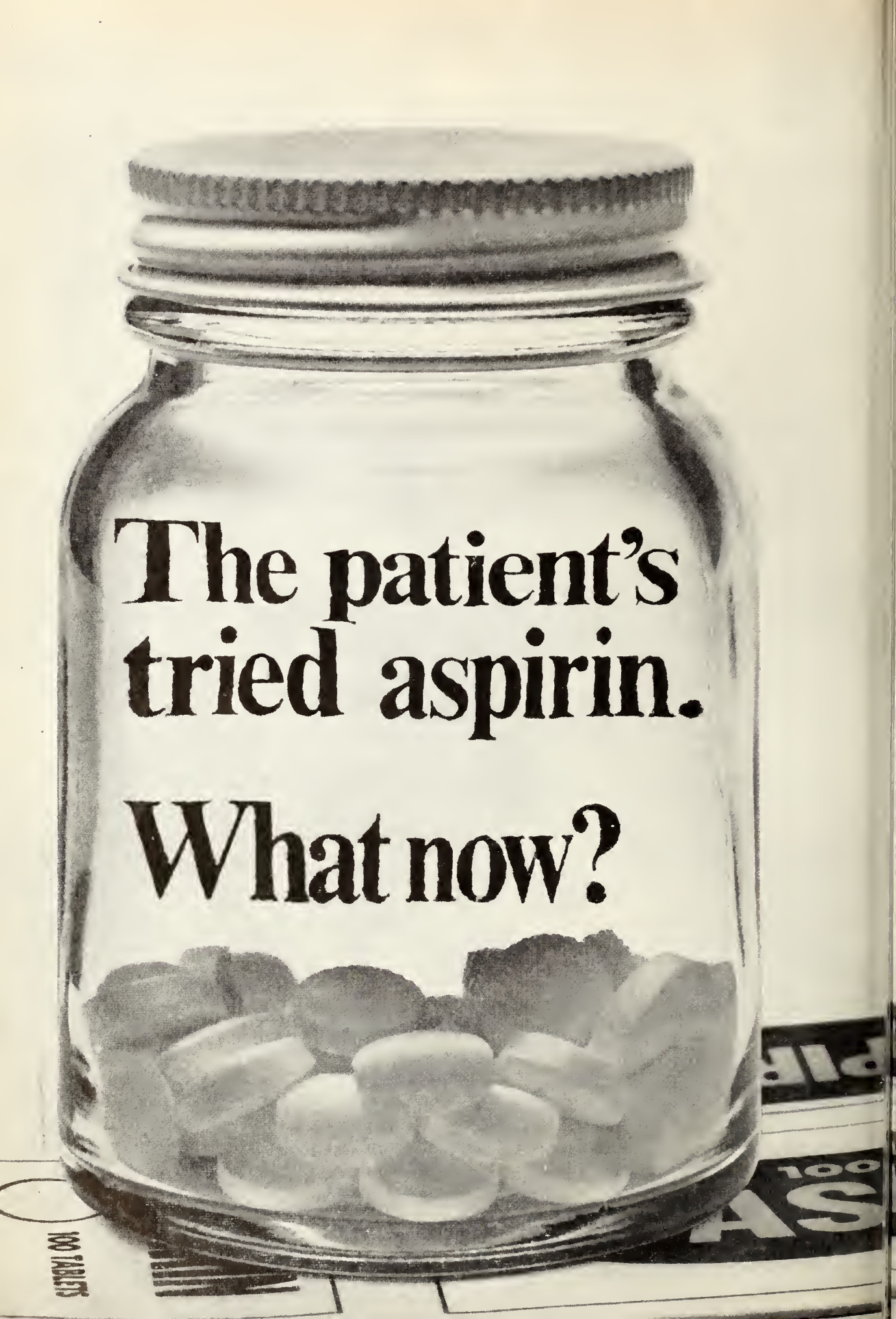
Parents' Reasons for Failure to Return Permission Slip	Number of Responses	% of All Responses	Permission obtained?		
			Yes	No	No Answer
1. Believed that earlier "measles" vaccine was protective.	87	31%	79	2	6
2. Permission slip returned to school late.	38	13%	38	-	-
3. Permission slip was lost or destroyed.	47	17%	47	-	-
4. Prefers consultation with family physician.	20	7%	--	18	-
5. Child has had rubella.	13	5%	7	4	-
6. Interviewer unable to reach parent.	23	8%	--	-	23
7. Child has received rubella vaccine from family physician.	10	4%	--	10	-
8. Child or family member has condition contraindicating vaccination.	5	2%	1	4	-
9. Does not want child to suffer discomfort of vaccination.	5	2%	3	2	-
10. Child has not been in school since slip was distributed.	3	1%	3	-	-
11. Prefers to use night clinic rather than school clinic.	5	2%	--	5	-
12. Child has moved to a new school.	3	1%	--	-	3
13. Vaccine may not be safe.	2	½%	--	1	1
14. Other or no reason given.	22	8%	21	-	1
Total	283	100%	199	50	34
	Percent of Total		70%	18%	12%

Results

Table 1 categorizes parents' reasons for their failure to return a total of 283 permission slips and shows the number of parents who granted permission for rubella immunization (199) and the number who still refused immunization for their child (50) after talking with the interviewer. It is important to note that by far the most common (31 per cent) reason for failure to return the permission slip to school was the parents' belief that the child had already received a protective "measles" vaccine. A rubeola immunization campaign had been conducted in this county about one year earlier and, although considerable effort had been directed toward publicizing rubella as a disease different from rubeola, misunderstanding was widespread.

The immunization clinics were held both in schools during the day and in county health department buildings in the evenings. Eighty per cent (80%) of the school-age children and 69 per cent of those aged one through four, or 75 per cent of the total population aged one through nine, received rubella vaccine. Two thousand seven hundred seventy-

(Continued on Page 542)


The patient's
tried aspirin.
What now?

There's a good chance your patient needs more than a non-prescription analgesic for pain relief. Especially after self-medication has failed.

Because continuing, increased pain and discomfort may in part be a reflection of anxiety, Equagesic is worthy of consideration. In a single, non-narcotic preparation, it helps relieve pain . . . *and* associated anxiety and tension.

Tablets

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

IN BRIEF

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

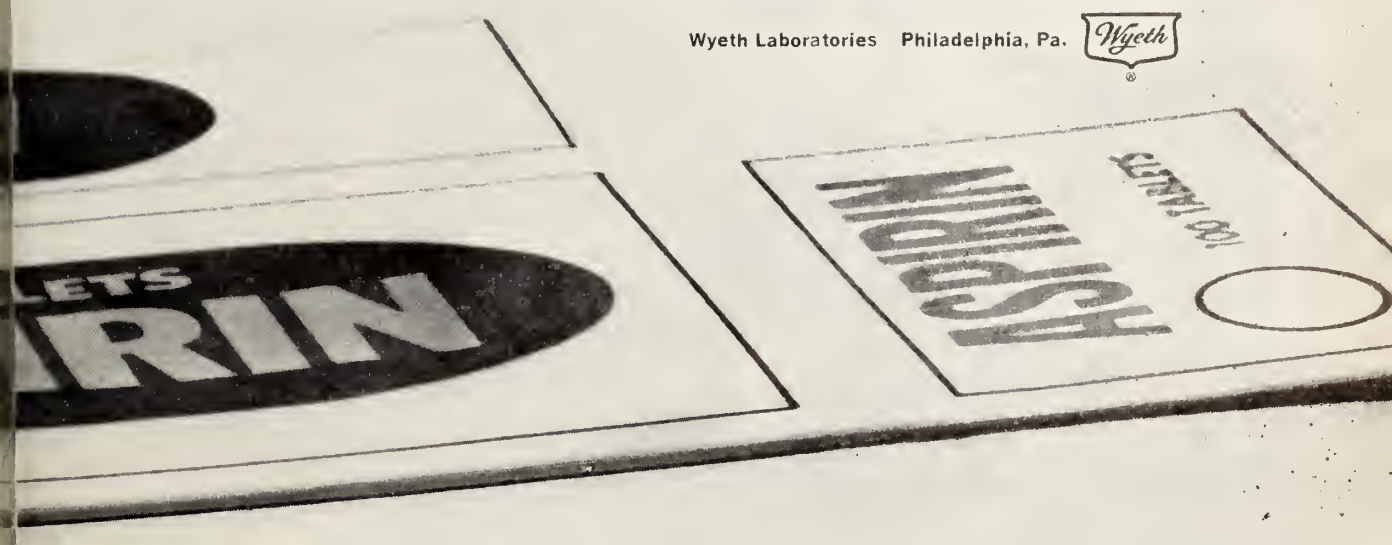
Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa. Wyeth®



(Continued from Page 539)

seven (2,777) doses were administered with the jet injector guns. There were no post-vaccination complications or side effects reported. In addition to those immunized during this program, 28 parents stated that they had already had or planned to have rubella vaccine given by their family physician. Following the county-wide campaign, both private physicians and the health department reported greatly increased demand for rubella vaccine among those who had not received it at the special immunization clinics.

Discussion

The results of this survey of parents' reasons for failure to return vaccination permismission slips to school will be of considerable value in planning rubella immunization programs in other Alabama counties. It is first noteworthy that less than 20 per cent of parents refused to allow vaccination of their child after talking with the field worker, and most (65 per cent) of those who did refuse at interviewing planned to obtain rubella vaccination elsewhere. This result emphasizes the importance of personal contact with parents in following up initial vaccination refusals.

A second important point is the frequency (31 per cent) with which parents failed to recognize the difference between the previous "measles" vaccine and the present rubella vaccine. Publicity for rubella immunization programs must clarify not only the difference between the two diseases, but also must plainly state that the earlier "measles shot" did not provide protection from rubella. Nearly one third more permission slips would have been returned initially if this last point had been made clear. There was surprisingly little fear that the rubella vaccine was unsafe and little demonstration of reluctance to have children vaccinated in order to indirectly protect the pregnant women of the county.

Summary

During a rubella immunization campaign in an Alabama county, an interview survey of 283 parents who failed to return permission slips for rubella vaccination of their children was conducted. The most common explanation given for failure to return the permission slip was the belief that an earlier measles vaccine also conferred immunity to rubella. More than 70 per cent of parents who had initially refused consented to rubella immunization for their children when interviewed by Immunization Project field workers.

This study emphasizes the importance of publicizing the difference between measles and rubella immunizations and the usefulness of follow-up interviews in promoting participation in rubella immunization programs.

Bibliography

1. Witte, John J., et al.: Epidemiology of Rubella, American Journal of Diseases of Children, 118: 107-111, 1969.

2. Recommendations of the Public Health Service Advisory Committee on Immunization practices, Rubella Virus Vaccine Prelicensing Statement, Morbidity and Mortality Weekly Report, Vol. 18, No. 15, 1968.

3. Alabama State Laboratories—unpublished data.

4. Cooper, Louis Z. and Saul Krugman: The Rubella Problem. Disease A Month, Year Book Medical Publishers, Chicago, February 1969.

5. Cooper, Louis Z. "Rubella: A Preventable Cause of Birth Defects," Birth Defects: Original Article Series, Vol. 4, No. 7, The National Foundation, New York, 1968.

Single Health Plan Futile

A single plan to solve all problems in the delivery of medical and health care will not be found, Dr. Gerald D. Dorman, AMA president told the House of Delegates in New York. "The profession must develop incentives to extend the effectiveness of all personnel and resources. Medical attention must be oriented to the patient—not to an institution."

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69



Appearances may be deceiving



It may be tetracycline

but it's not ACHROMYCIN® V
Tetracycline HCl

unless it bears this signature.



250 mg. and 100 mg. capsules

ontraindications: Hypersensitivity to tetracyclines.
arning: In renal impairment, since liver toxicity is possible, wer doses are indicated; during prolonged therapy nsider serum level determinations. Photodynamic action to sunlight may occur in hypersensitive persons. notosensitive individuals should avoid exposure; scontinue treatment if skin discomfort occurs.
ecautions: Nonsusceptible organisms may overgrow; treat perinfection appropriately. Tetracycline may form a able calcium complex in bone-forming tissue and may use dental staining during tooth development (last half of egnancy, neonatal period, infancy, early childhood).

Side Effects: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

530-9



symptoms of mixed anxiety-depression are rarely clear-cut...
but they are often a clear indication for

Mellaril®
(thioridazine)
25 mg. t.i.d.

effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69-384

Physician's Fiscal Profile

By J. Jerry Wood, J. D.

How is your economic health? Physicians have classically advocated regular physical check ups for the public, while many have ignored periodical fiscal reviews for themselves.

The average physician earns the greatest lifetime income of any professional. According to the report of the Committee on Labor and Public Welfare in 1963 the average physician's earnings between the age of 18 and 64 was $717,000. With this earning potential the wise physician must appropriately plan his current expenditures, his tax liability and the disposition of his estate.

The physician in 1969 must be cognizant of the changes in tax laws. For example, the Internal Revenue Service in August indicated that it was giving up the fight on taxation of professional service corporations. However, the Senate Finance Committee in amending the Tax Reform Bill of 1969 immediately penalized professionals taking away some of the tax incentives of the corporate form of practice. The physician, his attorney and accountant must stay aware, flexible and adaptable.

There are many factors other than taxes to be considered when one develops inter vivos trusts, makes inter vivos gifts, etc. Gift taxes are to be considered. The gross taxable estate must be evaluated, adequate cash with which to settle the affairs of the estate must be planned and provided for.

A Will is the most important type of estate planning. A Will directs the place and manner of burial; provides for distribution of property in a manner different from that in the statutes of descent and distribution; disinherits children; provides for tax savings; provides for tax apportionment; provides for tax-free gifts; selects estate fiduciary; exempts the estate fiduciary from giving bond; gives the estate fiduciary powers to do the job efficiently, expeditiously and save expense; provides for a marshaling of assets in case of need; appoints a guardian for minors; exerts posthumous control over property; revokes gifts causa mortis; adjusts advancements; provides for control over a business; provides for continuance of a business; allows a testamentary estate plan to be integrated with an inter vivos trust, contract, and life insurance; puts surviving spouse to an election; is an ambulatory estate plan; enables the creation of a testamentary trust which can, in general, offer the advantages of an inter vivos trust as to administration and distribution; when well drafted the Will provides for a smooth administration of the testator's estate thus saving time and expense.[1]

In planning your Will, you should give consideration to: The amounts that certain persons may receive as beneficiaries of your life insurance, the financial needs of your wife, your children and relatives, and any mental or physical impairments of any living children which would merit an unequal distribution of your estate.

The financial needs of your children, if your widow should remarry, gifts that you may have given to any of your children or others which should be treated as an advancement on their inheritance, leaving specific items of personal property, such as jewelry, art projects, antique furniture, etc., to those beneficiaries who may have a particular appreciation for such items, particular services or attention which any of your relatives or others may have rendered you

[1]Forms for Wills and Estate Planning, p. 1-2, Rollison and Eshelman, 1967.

during periods of illness or other need. The making of gifts during your life time to your heirs and loved ones to lower inheritance and estate taxes. Providing for gifts to a particular church, medical school, hospital, or other charity. Providing for a distribution of your estate and manner that will avoid dissension among your heirs and relatives and assure respect for your memory.[2]

Since a will is a legal document, your attorney is likely to use legal terms when he discusses the subject with you and when he drafts your will. To the extent that precise draftsmanship allows, attorneys of the modern school try to express legal concepts in simple language. However, many technical words used in connection with wills do not have synonyms in common usage. The following is a glossary of terms relating to wills.

Administrator: a person or institution authorized by the probate court to manage and distribute the property of a person who dies without a will; if a woman, the term is *administratrix.*

Attestation: the act of witnessing a will at the request of its maker and signing it as a witness.

Bequeath: to give personal property by will to another.

Bequest: a gift by will of personal property; it is synonymous with *legacy.*

Codicil: a supplement to a will that modifies it in some respects; a codicil requires the same formalities of execution as a will.

Decedent: a deceased person.

Devise: the act of giving real property by will.

Devisee: one to whom real property is given by will.

Executor: a person or institution named in a will to manage and distribute the property of the maker of the will in accordance with its provisions; if a woman, the term is *executrix.*

Holographic will: a will that is entirely handwritten, dated, and signed by the maker himself; some states do not require such wills to be authenticated by the signatures of witnesses.

Intestate: a person who dies without making a valid will is said to die *intestate.*

Nuncupative will: an oral will. Some states recognize such wills when made by a person during his last illness, or by a mariner at sea, or by a soldier or sailor in battle, and usually only with respect to estates involving personal property of limited value. A further requirement is that it must be reduced to writing by one or more witnesses and probated within a specified time.

Personal property: any kind of property other than real estate.

Per stirpes: property left *per stirpes* is divided equally among the decedent's children. If one of the children is dead, his or her children have a right to an equal part of their parent's share.

Probate: the procedure for offering official proof of the validity of a will in court.

Probate court: a court that has jurisdiction over wills, the administration of estates, and related matters.

Real property: real estate.

Testament: the terms *will* and *testament are synonymous.*

Testate: a person who dies leaving a valid will is said to die *testate.*

Testator: one who has made a will; if a woman, the term is *testatrix.*

Will: the legal declaration of a person with respect to the disposition to be made of his property after his death.[3]

[2]JAMA, Physicians' Guide to Wills, Trust, and Estates; Bernard B. Hirsh, Volume 181 No. 3, July 21, 1962.

[3]Ibid, JAMA.

Obviously, in a fluid and rapidly changing economy with changing tax laws and changing conditions, it is imperative that individuals look intelligently and often at their economic and fiscal health. Not only should one be concerned about estate planning, he should be aware of the advantages and disadvantages of postponed income as opposed to receiving income presently.

Some individuals have purchased tax sheltered annuities to provide for a retirement. The funds placed in the annuities together with interest earned will be ordinary taxable income when the individual takes these funds out of the annuities either as cash withdrawals or as retirement income; or when they are paid to his beneficiaries. Deferral of the tax money may work to the individual's advantage depending on (1) the investment yield applied to the funds in the annuity, and, (2) whether the tax rate applicable to him is higher or lower when the annuity funds are distributed.

Personal cicrumstances will determine whether tax sheltered annuities are to one's advantage. The tax sheltered annuity works to the individual's disadvantage when the money is distributed if: (1) income tax rates have increased substantially, (2) he has fewer personal exemptions, (3) his total in taxable income is at current or at higher levels, (4) it has been credited with a lower rate of interest than he could earn.

It could work to the individual's advantage if, when the money is distributed: (1) income tax rates have been substantially reduced, (2) he has more personal exemptions than he has currently, (3) his total taxable income is lower than it is currently, (4) the benefits to be gained from interest earnings on money that otherwise would be paid in tax are sufficient to offset a higher tax rate, (5) it has been credited with a higher rate of interest than he would have earned.[4]

[4]Stuart Schwarzschild, Qualifications for and advantages of tax sheltered annuities, Economic Review, Atlanta, August 1967.

Those neglecting fiscal health would be wise to look at it now. Consult your attorney, your banker, your accountant and stay abreast of changing conditions which affect your financial well being.

Cyclamate In Dietary Foods

General Foods Corporation has announced that its D-Zerta line of dietary food products will continue to be available in grocery stores for diabetics and others with special health problems. In the announcement it calls attention to the exceptions in the cyclamate ban on such health foods.

Meantime, however, the corporation reported that it is working on the development of cyclamate-free formulas for the D-Zerta products and expects to have reformulated products, which will comply with the Federal regulations, available before Feb. 1, 1970.

Ef-
fic-
iency

Dicarbosil®
ANTACID

Your ulcer patients and others will confirm it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102


Each 5 cc. contain erythromycin estolate equivalent to 250 mg. erythromycin base.
When mixed as directed, each 5 cc. will contain erythromycin estolate equivalent to 125 mg. erythromycin base.
When mixed as directed, each cc. will contain erythromycin estolate equivalent to 100 mg. erythromycin base.
Each 5 cc. contain erythromycin estolate equivalent to 125 mg. erythromycin base.
Each tablet contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule® contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule contains erythromycin estolate equivalent to 250 mg. erythromycin base.
The many forms of Ilosone®
Erythromycin Estolate
Lilly
Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206
900761

THE JOURNAL
of
THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA
Published Under the Auspices of the Board of Censors

Volume 39 December, 1969 No. 6

Specialized Hospital Care Of Coronary Artery Disease

Charles E. Rackley, M. D.

Coronary artery disease is the most prevalent of all disorders affecting the heart. An estimated 600,000 people per year succumb to the complications of this disease. Significant technical advances in monitoring equipment for cardiac patients have been accomplished in the past decade. Skilled medical personnel and equipment for this disease have been concentrated in hospitals to create Coronary Care Units. Although considerable variations in the technical facilities may occur, virtually all hospitals currently have, or plan to have, such intensive care units for treating coronary artery disease. The coronary care units provide immediate medical treatment for the complications of recognized myocardial infarction which include arrhythmias, heart failure, shock and emboli. These complications and their management in a coronary care unit will be discussed.

I. Arrhythmias.

The introduction of monitoring facilities for continuous observation of the electrocardiogram in patients with acute myocardial infarction significantly increased the recognition of cardiac arrhythmias. Although the incidence of arrhythmias during acute myocardial infarction was earlier thought to be 10-20 per cent, continuous electrocardiographic monitoring has demonstrated that approximately 90 per cent of patients with acute infarction have disturbances in the basic cardiac rhythm during the first 48-72 hours after the acute infarction. Such arrhythmias include premature atrial and ventricular beats, sinus bradycardia, complete heart block, sinus tachycardia, atrial flutter, atrial fibrillation, and finally ventricular tachycardia and fibrillation. Experienced coronary care unit nurses can recognize many of these arrhythmias and initiate the appropriate therapy while the physician is being notified. As soon as a patient is admitted to a coronary care unit, an intravenous route for further drug administration should be established. Xylocaine in a two per cent solution (1000 mgm in 500 cc of dextrose in water) should be prepared, and with the first ectopic beat, the intravenous infusion of xylocaine should be started. The rate of infusion should be adjusted to abolish the ectopic beats, and if this is inadequate, 50 or 100 mgm of xylocaine should be injected as a single dose. If the ectopic beats continue at intermittent intervals, oral antiarrhythmic agents, such as pronestyl 500 mgm every four-six hours, can be started. Should a sustained rapid atrial

Dr. Rackley is Associate Professor of Medicine, Director of Coronary Care Unit, University of Alabama Medical Center, Birmingham, Alabama.

or ventricular tachycardia develop, emergency cardioversion may be required.

Although complete heart block occurs in less than ten per cent of the patients with acute myocardial infarction, this complication frequently requires more than intravenous drug administration. Diaphragmatic infarctions have a three-fold incidence of complete heart block compared to the anteriorly located infarctions. On the other hand, the mortality is probably three times as great in the anteriorly located infarctions, than in the diaphragmatic area. Should the heart rate fall below 50 in a patient with acute infarction, an intravenous dose of atropine either 0.4 or 0.6 mgm should be given initially to increase the heart rate. Further slowing of the sinus rhythm or the development of second degree heart block, that is a P-wave not followed by a QRS complex, indicates the need for a venous pacemaker. Since preparations are necessary for pacemaker insertion, it is much easier to perform this procedure under elective circumstances. While preparations are being made for pacemaker insertion, isoproterenol may be required for increasing the heart rate. This drug can be given in a solution of 0.2 mgm in 200 cc, so as to prepare a concentration of 1 mcg per cc. The drug can be given up to 5 to 6 cc per minute. Larger doses may be associated with cardiac irritability and further complicating arrhythmias. Nevertheless, it is necessary to be aware of the effects of this drug, since there may be some delay in pacemaker insertion in patients with complete heart block. Often the heart block in patients with diaphragmatic infarctions may progress from initial bradycardia to a second degree heart block to third degree or complete block. On the other hand, in anteriorly located myocardial infarctions complete heart block may develop without any previous progression in conduction transmission.

II. Congestive Heart Failure.

Congestive heart failure in a patient with acute myocardial infarction is attended by a 50 per cent mortality. Subtle clinical signs of heart failure may not be appreciated when the patient is first seen. Overt pulmonary edema with severe dyspnea and rales in the chest are easily detected, but heart failure will be detected more frequently if proper consideration is given to a tachycardia, a soft ventricular or proto-diastolic gallop and early radiographic signs of pulmonary congestion. These latter signs warrant digitalization and diuretics at an earlier stage in the management of acute myocardial infarction. Therefore, the heart rate, neck vein distention, lung rales and gallop heart rhythm should be evaluated several times each day after a patient has been admitted to a coronary care unit.

III. Cardiogenic Shock.

Cardiogenic shock complicating an acute myocardial infarction carries an even higher mortality than congestive heart failure and approaches 80-100 per cent. Cardiogenic shock may be defined as an arterial systolic pressure below 80 mmHg, or 30 mmHg below a previously recorded level, evidence of reduced blood flow, mental confusion, obtundation, sweating, cyanosis, cool clammy skin, or a urine output less than 20 ml per hour. Hypotension secondary to pain, analgesics or serious cardiac arrhythmias should be excluded before cardiac shock is diagnosed.

The two primary drugs for consideration in treatment of cardiogenic shock associated with acute myocardial infarction are norepinephrine and isoproterenol. Although norepinephrine further constricts the peripheral arterioles, the vigor of cardiac contraction is augmented. Norepinephrine is administered intravenously as four cc diluted in 1000 cc of dextrose in water and at a rate of 1-2 cc per minute. Should local infiltration occur, which may subsequently cause tissue necrosis due to its extreme vaso-constrictor properties, either subcutaneous regitine or hydrocortisone should be injected locally to counteract the vaso-constriction. Isoproterenol can be administered in the similar concentration as in the treatment of complete heart block. Isoproterenol not only increases

the heart rate but also enhances the vigor of cardiac contractions. At present it is difficult to predict which patients in cardiogenic shock will respond to either of the drugs and occasionally the patient may benefit from the combined use of the two drugs. A further consideration in the management of cardiogenic shock is that of volume replacement, since certain patients in cardiogenic shock may manifest the vascular changes of hypovolemia. In order to identify such a hypovolemic state, an accurate measure of the left ventricular filling pressure derived either from a pulmonary artery catheter or a central venous catheter is required. Even though this may require fluoroscopy and passage of a cardiac catheter, certain patients have been reported to significantly improve following dextran infusion in cardiogenic shock. Since the patient must closely be observed for the earliest signs of pulmonary edema, such therapy as this can best be managed in a coronary care unit.

IV. Emboli.

Intravascular emboli, both venous and arterial, may complicate acute myocardial infarctions. Venous thrombi may arise from the calf veins, the deep pelvic veins, or in rare incidences in the right side of the heart, and pulmonary embolism with infarction represents a grave complication in acute myocardial infarction. Furthermore, the infarction involving the endocardium of the left ventricle may provide a site for mural thrombus and systemic emboli. Both of these conditions are most effectively managed with anticoagulation. While in a coronary care unit, this is best performed by an intravenous administration of heparin in sufficient doses to maintain the clotting time between 20 and 30 minutes. Although heparin can be given deep subcutaneously over the iliac crest, the smoothest anticoagulation is maintained with intravenous administration. The question of the efficacy of anticoagulation in acute myocardial infarctions remains unanswered. Several prominent cardiologists still anticoagulate patients during the acute phase of the infarction and during the remainder of the hospital course. Anticoagulation following discharge from the hospital is left to the decision of the individual physician.

V. Miscellaneous Complications.

Additional problems in acute myocardial infarction include persistent or recurrent chest pain, the development of pericarditis and hiccups from diaphragmatic irritation of the myocardial infarction. Ventricular rupture of the free wall, as well as the intraventricular septum, can occur several days following a myocardial infarction. Later complications in the convalescent period of these patients include shoulder-hand syndrome with swelling and pain of the affected upper extremity. Pericarditis or pleuritis may be a recurrent problem after the acute episode associated with high fever and leukocytosis. Salicylates, and in rare instances steroids, may be required to control the associated pain with the post-myocardial infarction syndrome.

VI. Role of the Coronary Care Unit

The role of the coronary care unit in the management of acute myocardial infarction is to provide more rapid recognition and institution of appropriate therapy in any of the complications which may develop. Continuous monitoring and available nursing personnel have significantly reduced the mortality due to cardiac arrhythmias. As mentioned earlier, experienced coronary care nurses may not only recognize arrhythmias but also institute appropriate therapy while the attending physician is being summoned. Unfortunately the problems of congestive heart failure and cardiogenic shock are still accompanied by excessive mortality, but the coronary care units may continue to contribute to the care of these problems by early recognition of heart failure and cardiogenic shock. No doubt newer methods for care and management of heart failure and cardiogenic shock are required and the development of

coronary care units is a major accomplishment in this direction.

Not only should patients with acute myocardial infarction be immediately admitted to a coronary care unit, but any patient that develops clear-cut angina pectoris for the first time or experiences definite change in frequency or intensity of his angina should be admitted to such a unit for further care. The pre-infarctional syndrome can sometimes be interrupted by immediate bedrest, anticoagulation and the attendant care that is available on the coronary care unit. The convalescent period may not be as long in such a patient that does not develop an infarction in the unit, but long term anticoagulation should be strongly considered in such a patient.

Patients that have undergone emergency or elective surgery of any type and are prone to develop myocardial infarction should similarly be observed for several days in the postoperative period in a coronary care unit. Patients with documented coronary artery disease, which would include known angina pectoris or previous myocardial infarction, should be observed very closely in the immediate postoperative period for any evidence of arrhythmia, heart failure, or hypotension. Such patients may resemble those with pre-infarction angina in whom myocardial infarction might be possibly averted in the coronary care unit.

VII. Summary.

Coronary care units with highly trained personnel in monitoring facilities can render the most up to date care to patients with acute myocardial infarction, the complications developing in acute infarction, the pre-infarctional syndrome, and the postoperative patient that may be considered a righ risk infarction prone patient. Newer methods may be developed in coronary care units to further reduce the excessive mortality associated with congestive heart failure and cardiogenic shock in patients with acute infarction. Coronary care units have already contributed significantly to the care of patients with coronary artery disease.

Pulmonary Function Testing For The General Hospital and Physician

D. S. Tysinger, Jr., M. D.

Dothan, Alabama

Part I—Normal Physiology:

If pulmonary function testing is to be understood it is absolutely essential that normal pulmonary physiology be understood. The following presentation is designed for simple understanding; not as a complicated discourse.

Diagram Number Two: This diagram pro- deep breath is taken, the spine straightened, and the ribs arched forward with the head back, one then gets the maximum amount of air in the lungs that is possible on an inspiration and one would have the lung at Volume A. With relaxation and resumption of a normal resting chest cage position, one would then notice that the chest cage volume would be reduced to Volume B. Starting from a resting chest cage volume, if one forcibly expels all of the air one can expel from the lungs by contracting the muscles of the abdomen and chest and by bending the spine forward, we have Volume C. Since the lungs are not completely collapsed at C, it follows that there is still air left in the lungs. If a needle is put into the pleural space and air from outside is let into the pleural space at the expiratory level of C, we would find that the lungs would further collapse into a dense mass around the hilus as demonstrated in D. All the elastic structures that are present in the fully expanded lung at A (bronchial tubes, alveoli, lymphatic ducts, vasculature, etc.) are still present in the collapsed lung at D. These elastic structures always act to collapse the lung but their elastic forces are kept from collapsing the lung by the air-tight chest cage and diaphragm.

Diagram Number Two: This diagram provides a pictorial presentation of the chest cage and the structures that are present in the lung which will undergo changes from full inspiration to the small dense mass around the hilus. In this diagram the prime concept is one of forces and, more specifically, of opposing forces. Force A is the force of the chest cage and of the diaphragm. This force can be applied to increasing the size of the chest cavity or to decreasing the size of

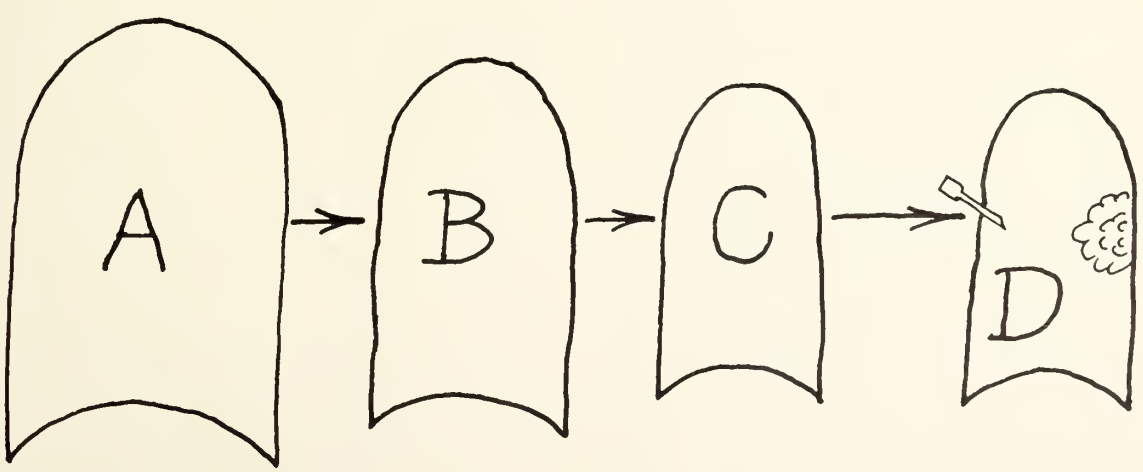


Diagram No. 1

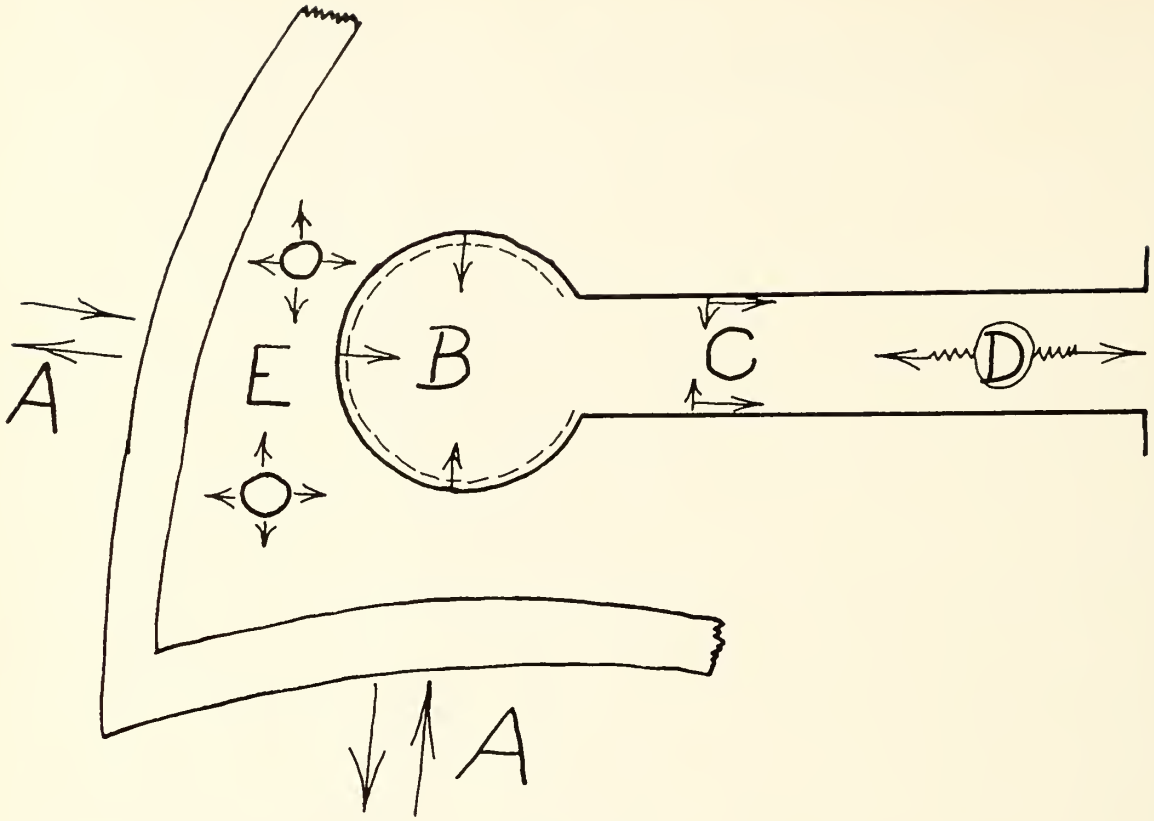


Diagram No. 2

the chest cavity. Force A is usually active in increasing the volume of the chest cage on inspiration and then passive in relaxing to return to the resting chest cage position before the next inspiration. Within the pulmonary tissue is found Force B or the alveolar force. This is a force that continuously tends to collapse. The alveoli have muscle fibers, elastic tissue and also a surfactant substance which lines the alveoli, the latter of which increases in its collapsing force as it is stretched and decreases in collapsing force as the alveoli get smaller. These two opposing forces act on an alveolar membrane which, the more it is stretched by Force A, the greater becomes Force B which tends to cause collapse. As Force A is released and as the size of the alveoli get smaller the force gradually reduces but not to zero and thus retards collapse of the alveoli. Next is Force C which is due to the elastic and muscular structures of the bronchial tubes. These tend to continually make the bronchial tubes smaller in diameter and shorter as in Diagram One. The elastic forces of C (the bronchial tubes), like those of the alveoli, are increased with elongation and dilatation of the tubes as Force A of the diaphragm and rib cage increases the chest cage diameter. This expansion and dilatation of the bronchial tubes occurs with, or after, the alveoli have been fully distended. The bronchial tubes, like the alveoli, tend to collapse and, with Force A removed, help the return to the resting chest cage position. Next is Force D. This is the air-flow resistance that is normally developed as air moves in and out. As inspiration occurs there is produced in the alveoli and bronchial tubes a pressure lower than that around the individual. This reduced pressure causes air from the outside to flow in through these tubes and then into the alveoli. The rate of flow of air depends, first, upon the negative pressure produced (the pressure difference) in the alveoli and in the bronchial tubes and, secondly, on the rate at which this change occurs. If one considers the air as molecules lined up in layers and

visualizes the bronchial tubes as they are with the ciliated lining, then one can picture the molecules of air adjacent to the cilia as marbles rolling over the ciliated area and bouncing up and down and, with this bouncing around, losing some of their forward momentum by frictional resistance. As this occurs this layer of molecules tends to bump into and slow down the next layer of molecules which to a lesser extent become irregularly arranged and bump into the next layer. Thus, as the individual breathes in, this frictional resistance is a retarding force to inspiration due to the molecular disturbance produced when the moving air molecules and bronchial tube walls meet. This is known as turbulence and is dependent upon the rate at which the air flows. If negative pressure at the alveolar level, or Force B, is developed quite rapidly and with great pressure difference between this area and the air around the patient, then turbulence is great and can cause a large reduction in air flow, or even obstruct the bronchial tubes. On the other hand, if this force is developed quite slowly and without great pressure differences, then Force D (frictional resistance to airflow) will be a small force. Since the tubes are all the time getting longer and larger upon inspiration, flows may increase. On expiration as the elastic forces begin to diminish, the spaces that air occupied in the alveolus and bronchial tubes in the chest cage, which had been bent out of shape, tend to collapse and return to their normal position. The air in the alveoli and next in the bronchial tubes is greater in pressure than the air around the individual and at the same time the bronchial tubes are getting shorter and smaller in diameter. Thus, the frictional resistance of Force D becomes a much greater retarding force to the collapse, or to expiration, than it does to inspiration. As these changes are occurring there is always the chest cage, or Force A, in opposition to Force B and C which are constant collapsing forces and which are retarded more or less by Force D, the frictional resistance of air as it moves in and out. Caught between these two groups of forces, which are in a tug-of-war, is the interstitial tissue in which the pulmonary capillary bed predominates. There is in one direction the collapsing force of B and C; in the other direction, the expanding force of A which puts a pull in both directions with a more negative force in area E. We can now visualize Force A starting to increase the chest cage diameter on inspiration. It must first produce a negative pressure in area E sufficient to cause expansion of Force B and Force C with whatever resistance may be produced by Force D. Thus, there is greater negative pressure in the interstitial tissue at E than in the alveoli at B and, in fact, the interpleural pressures so often referred to are really interstitial pressures at the capillary bed. As we visualize this in the opposite direction, as inspiration is completed and the individual begins to breathe out, Force A is now relaxed and is a passive force. Force B and C are active elastic forces that have been brought into play and, therefore, Force B and C collapse at a more rapid rate retarded only by the resistance developed by air flow of Force D. On expiration then, there is still this pull between two opposites which keeps Force E, or the area of interstitial tissue where the pulmonary capillaries reside, distended and the pulmonary capillaries open. Then we have, due to the opposing forces of A to B and C with or without the varying forces of D, a continuous and more negative pressure in E which causes blood flow both through inspiration and expiration.

Formula for (1) inspiration: Now with Forces A, B, C, D, and E pictured in our minds, we can write an algebraic expression for inspiration (Diagram 3). Force A is actively expanding and getting larger. It is actively resisted by Force B of the alveolus, Force C of the bronchial tubes and Force D of airway resistance. That would be expressed as $-(B+C+D)$ with a resultant negative state E existing in the interstitial tissue. $A-(B+C+D)$ is equal to inspiration. In looking at these, any disease that could effect A, B, C, D, or E, would tend to

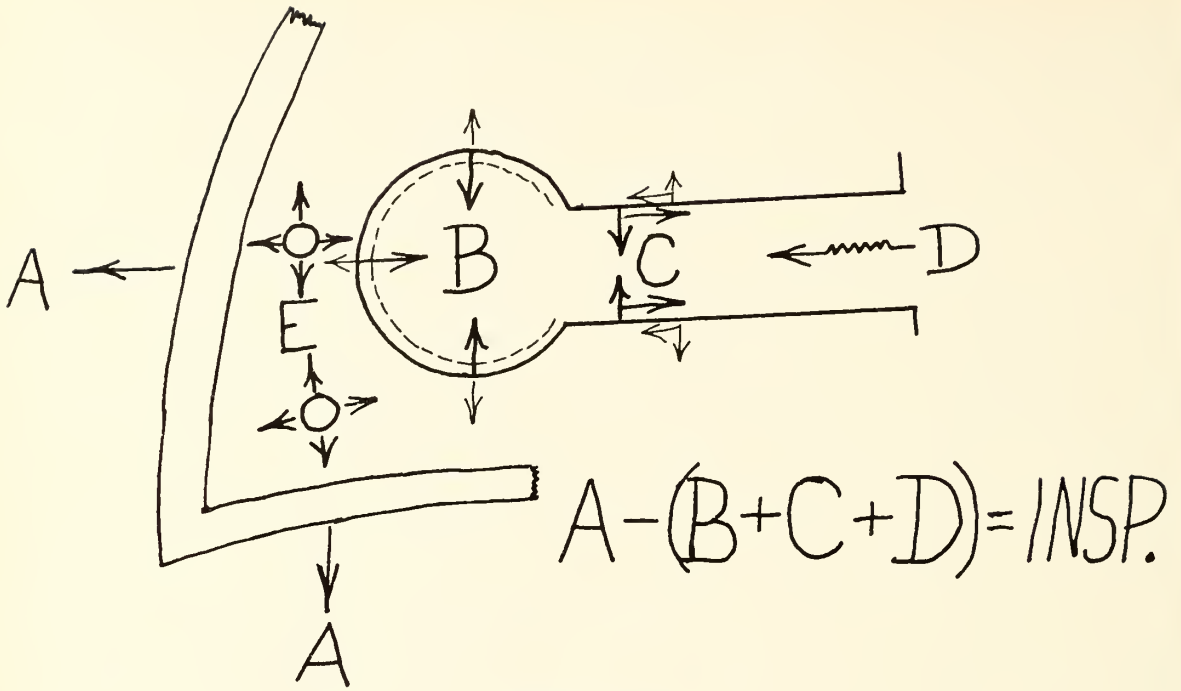


Diagram No. 3

interfere with the normal process that occurs on inspiration.

Formula for (2) expiration: Since the chest cage is relaxed and is beginning to return to normal position it is now a positive collapsing force. B and C are collapsing forces and react immediately, faster than either the diaphragm or chest cage. Here, the only retarding factor is the progressively smaller size of the alveolar space and the progressive shortening and decreasing in diameter of the bronchial tubes which increases the resistance to air flow producing turbulence. On expiration our equation changes somewhat and is (A+B+C)—D is equal to expiration. Since the rate at which these forces occur varies, we find that there is still a resultant negative state at E; however, not as negative as it was on inspiration.

Thus, we end up with five factors, all of them pressure-oriented, that have to do with normal breathing. Likewise, we can have five different areas in which we can have abnormalities which would interfere with normal breathing. We can speak of each of these as a factor disease. For instance *A factor diseases* would include muscle paralysis and those diseases which cause poor movement of the chest cage; chest cage deformities (such as dorsal kyphosis, funnel chest, etc.), fixation of the chest cage as in the emphysematous patient and man-made restrictions such as rib binders and restrictive clothing.

B factor diseases would include interstitial edema, alveolar fluid or pulmonary edema, fibrosis with fixations (such as scleroderma, post infectious, etc.), hyaline membrane disease, alveolar capillary block, (Hammond-Rich type), loss of alveolar space in elastic tissues disease such as is seen in emphysema and pneumonia.

C factor diseases would include bronchospasm, peri-bronchial edema and vascular engorgement, inflammatory disease with swelling and scarring, secretions and fluid, plugs, and loss of elasticity such as emphysema.

D factor diseases would include all of C plus increased pressure differences between the mouth and alveoli as produced in anxiety

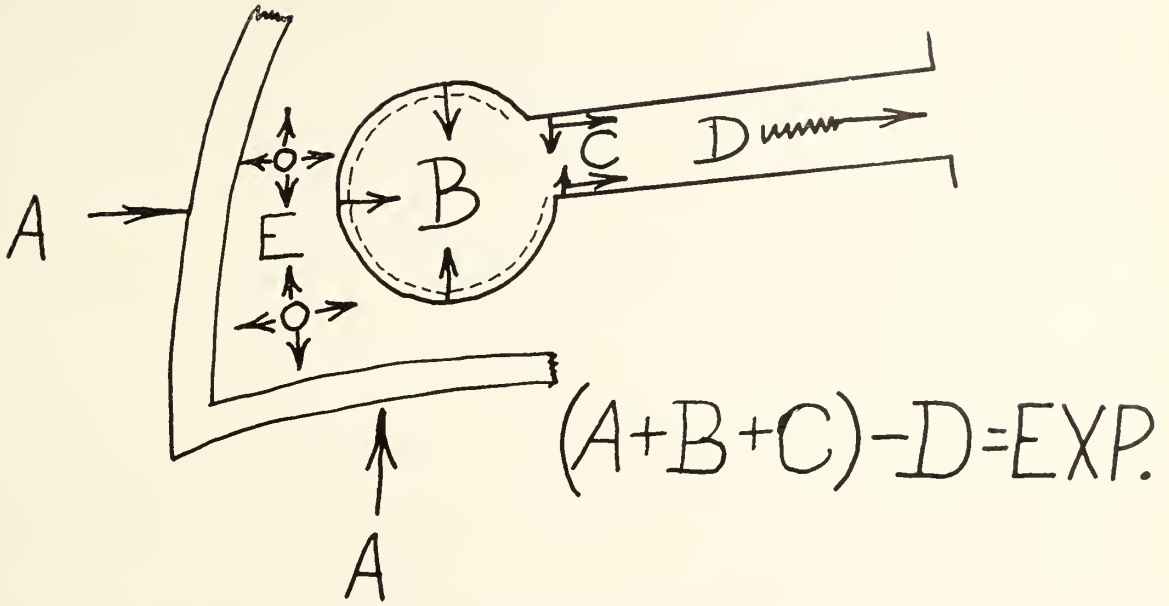


Diagram No. 4

and panic states. These would include increased rates of change of alveolar pressure in relation to the mouth, increased flow rates produced by machines and increased mouth pressure produced by mechanical means.

E factor diseases would include complete loss such as pneumoconiosis and block fibrosis, fibrotic diseases such as scleroderma, loss of elasticity such as emphysema, increased pressures at the alveolar level (especially the expiratory pressures where there is a loss of elasticity), pulmonary endarteritis with loss of vasculature in relation to alveoli and sclerosis with loss of alveoli in relation to vasculature.

Thus, we can begin to get a picture of the various types of abnormalities that occur in pulmonary disease by knowing what they do and realizing what effect they would have on one of the five pressure factors that have to do with normal pulmonary homeostasis.

As already demonstrated in Diagram Number One, there is a certain amount of air that remains in the lungs at all times. As we breathe in and out, the air we breathe in must be mixed with the air that remains in the lungs all the time, this being termed interpulmonary mixing, and it is not equal in all parts of the lung, even in the normal.

Diagram Number Five: This diagram is presented to explain the basic inequality of the mixing of air as it is breathed in the normal individual. (A) The spine as it is normally bent with the ribs attached in a semi-fixed position can increase chest cage diameter just by straightening and flattening which forces the ribs upward and forward. As this occurs, the area of the lung next to the spine and posterior ribs gets no movement; only that portion of the lungs in the front and sides. This is again demonstrated in section B where is seen the chest cut in a sagittal direction with the heart positioned in front of the spine in the middle of the chest cavity and the chest cage drawn in heavy lines in expiration and then in dotted lines as inspiration occurs. The dotted line shows the movement of the heart forward. It also moves downward. One can see by this that, as the chest cage is expanded, the anterior part of the lungs and, to a lesser extent the lateral portion, are expanded by chest cage expansion. Referring to Part C of Diagram 5, one notices that, from resting position to inspiration, as shown to a certain ex-

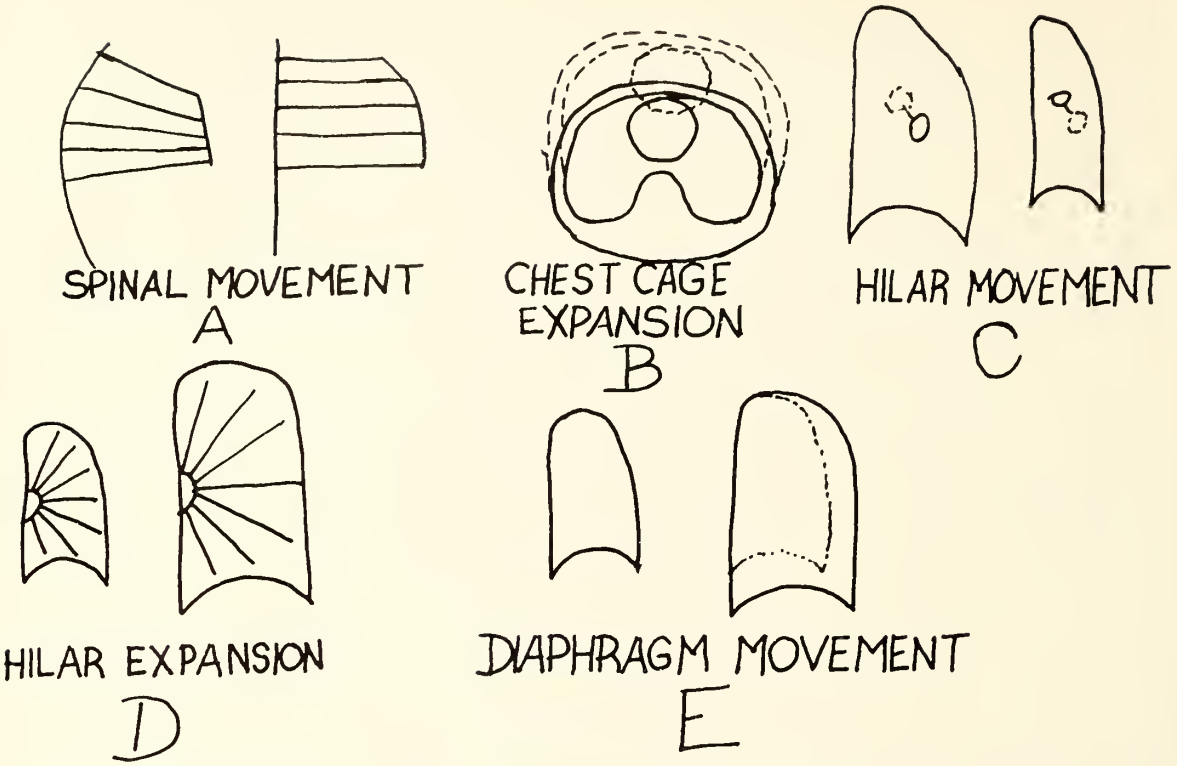


Diagram No. 5

tent in B, the chest cage increases in diameter and the heart and hilar areas are moved forward and downward with this inspiration. It is only after this movement occurs that there can be any expansion to the apex, lateral and posterior (or dorsal) segments of the lung as a result of chest cage expansion. In D there is represented the hilus and the tracheo-bronchial structures at resting chest cage position. Then, proceeding to inspiration, it is to be noted that, as the chest cage increases in diameter, the tracheobronchial structures must be elongated, dilated, and fanned out to allow first the filling of the subpleural areas and then, only after the bronchial tubes fan out and elongate, are the middle and hilar areas able to take part in breathing. Part E in Diagram 5 has to do with the movement of the diaphragm. As the diaphragm moves down, resisted by the abdominal organs, it tends to increase the AP and lateral diameter of the chest. In addition, it tends to increase the head to foot diameter. It is only as the diaphragm moves that all of the lung can be increased in its degree of aeration. The most frequent and most easily aerated portions of the lung are the anterior, lateral and diaphragmatic portions. Those portions behind the hilus and from the hilus to the apex are the least expandible and those portions medially located around the hilus do not receive the same aeration as the peripheral areas of the lung. Thus, interpulmonary mixing in the normal is anything but uniform.

The pulmonary circulation is divided into two systems: (1) the bronchial artery supply which comes from the left heart is completely arterial blood and supplies all the non-aerated portions of the lung including the vasa-vasorum of the pulmonary artery, bronchial artery, and all the bronchial structures. (2) The pulmonary artery supply which comes from the right heart does little branching until it gets to the pulmonary capillary bed. The blood is arterial with the exception of the carbon dioxide and oxygen content. At the pulmonary capillary bed this blood becomes arterial and at this level there is a forward

and backward flow, to-and-fro in fashion, of this now arterial blood which supplies this area. There are communications between the bronchial artery blood supply and the pulmonary artery blood supply at this level which in the normal accounts for very little circulation from the bronchial artery to the pulmonary capillary bed. Only the pulmonary arterial bed will be discussed. The bronchial artery bed is a peripheral artery and obeys all the regulating mechanisms the same as other peripheral arteries throughout the body. The pulmonary artery is different here. There is stimulation to arteriolar vasoconstriction to protect the pulmonary capillary bed by elevated capillary bed pressures. Pulmonary artery pressure is elevated by low oxygen tension, high carbon dioxide tension, high histamine levels, and high pulmonary capillary bed pressures which may arise from disease on the left side of the heart.

At the arterial end of the normal capillary bed hydrostatic pressure produced by the heart tends to overcome the circulating osmotic pressure of electrolytes protein, etc., and tissue pressure, both of which oppose hydrostatic pressure. Fluid, therefore, tends to leave the vascular system in the capillary bed space at the arterial end. As fluid leaves, the osmotic pressure goes up, tissue pressure remains the same, and through the traversing of the capillary bed, hydrostatic pressure goes down so that at the venous end of the capillary bed osmotic and tissue pressure greatly outweigh the hydrostatic pressure and fluid returns to the vascular system. Therefore, in the normal individual, the hydrostatic pressure at the arterial end is sufficiently greater than the osmotic pressure and tissue pressure to allow the exudation of fluid with nutrients and oxygen into the tissues. At the venous end of the capillary bed, the osmotic pressure has so risen that there is an influx of fluid back into the capillary bed which returns to the left heart. That fluid which does not return into the capillary bed is usually picked up by the pulmonary lymphatic system. Extremely high oxygen tensions cause lymph stasis whereas high carbon dioxide levels cause a marked increase flow in lymph up to a liter per hour back into the vena cava. Abnormalities may thus be produced in the circulatory system by putting a greater negative pressure in the alveoli which counteracts tissue pressure and osmotic pressure and supports hydrostatic pressure and thereby causing edema. Increased alveolar positive pressure will support tissue and osmotic pressure and retard the effect of hydrostatic pressure which would affect the nutrition of the pulmonary capillary area. Since circulation can be shifted from one area of the lung, depending on oxygen saturation and CO_2 levels, then there can be differential circulation of the lungs. The diaphragmatic and anterolateral surfaces receive the greatest circulation; the posterior and apical areas receive the least circulation from the pulmonary artery supply.

Now, as has been pointed out, there are several factors to be considered in normal physiology. First is volume exchange. Next is interpulmonary mixing of air. Then is perfusion of the lungs by blood. The relationship of ventilation (or where the air goes) compared to perfusion (or where the blood goes) is properly referred to as the ventilation perfusion ration or VQ ratio. The VQ ratio is expressed as the liters of blood going through the lungs for each liter of air breathed. As an example, an individual who has a cardiac output of four liters a minute and who breathes five liters a minute of air, then has a ratio of 0.8. As diseases are considered that affect either the ventilation or the perfusion, or both, there are changes in this VQ ratio.

So far we have discussed the circulation of the blood through the lungs and how it varies in different portions. There was discussion of the movement of air in and out of the lungs and how it varies (interpulmonary mixing) and discussion of the various forces that have to do with getting air in and out of the lungs, and which to a certain extent effect the circulation of blood through the pulmonary capillary bed.

The purpose of the lung is threefold. First, oxygen is transported to the alveolar capillary bed and transferred to the blood stream for distribution to the body tissue cells. Second, carbon dioxide produced in the process of metabolism can be transported by the blood stream to the alveolar capillary bed, transferred into the alveoli, and ventilated off by breathing. Third, there is rapid control of the pH of the blood. The primary buffer system in the normal individual is the carbon dioxide-bicarbonate buffer system. If the blood gets too acidic due to a build-up of metabolic acids in the blood then breathing becomes deeper and faster, more carbon dioxide is blown off, and the remaining bicarbonate is left to buffer this acid instead of the carbon dioxide. If there is a development of alkalosis due to metabolism then the breathing is slowed and carbon dioxide is held to buffer this alkalotic state. Therefore, the ultimate function of the lung is to keep pH at its proper level which is between 7.35-7.45 by adjusting carbon dioxide levels. Second, there is maintenance of arterial oxygen saturations between 80-100 mms. of mercury pressure which is 95-97 per cent saturation of the hemoglobin. Third, there is the adjustment of the carbon dioxide to usually 35-45 mms. of mercury pressure. When the pH is normal the carbon dioxide-bicarbonate ratio is usually one to twenty.

The controlling factors that keep all these elements in balance are primarily the carbon dioxide (PCO_2 level) and the pH (degree of acidity of the arterial blood). In order to understand this, if one imagines carbon dioxide (arterial PCO_2) as a lake with a dam at one end with a spill-gate, there is then a level of carbon dioxide that will be maintained at the level set by the spill-gate. In the normal individual, this spill-gate is 40 mmHg. pressure. If the individual increases his activity and produces more carbon dioxide, then the level of the lake goes up and the carbon dioxide spills over, the patient breathes faster and PCO_2 is maintained at 40 mms. of mercury pressure. The reverse happens should PCO_2 drop below 40 mmHg. because of the level set by the spill-gate. Next one should understand that the mechanism that controls the spill-gate is the degree of acidity or pH. If there should develop metabolic acidosis, renal failure, infection and disease processes, diabetic acidosis, etc., the blood gets more acid, or the pH goes down below 7.35. At this point the spill-gate is lowered and the PCO_2 is blown off and the bicarbonate left in the blood stream now buffers the acids produced other than CO_2 and by this means maintains the pH of the blood stream. If on the other hand the blood gets more alkaline than it should be due to metabolic causes, then the spill-gate is elevated and breathing is slowed and CO_2 is retained until the new level set by the pH spill-gate is reached and, once again, PCO_2 acting as an acid is buffering the excess alkaline material in the blood stream so that pH is back to normal. In this way, in the normal individual, pH and PCO_2 are the controlling factors of breathing. We would like to point out that this is not the case in the individual with respiratory acidosis or respiratory alkalosis which are abnormal states and will not be discussed in normal physiology. This is the pattern by which this breathing mechanism is controlled and by which homeostasis of the body is maintained.

(This is the first in a series of seven articles)



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N.J. 08101

in acute and chronic diarrheas

LOMOTIL® SAVES...

TABLETS LIQUID

Each tablet and each 5 cc. of liquid contain
diphenoxylate hydrochloride .....2.5 mg.
(Warning: May be habit forming)
atropine sulfate, 0.025 mg. (1/2,400 grain)

body fluids... electrolytes... patients from exhaustion

Lomotil acts promptly and directly to lower the excessive intestinal motility of diarrhea. This therapeutic restraint on the overactive bowel allows a normal or more nearly normal reabsorption of water and electrolytes.

The proficiency of Lomotil in conserving body fluids and electrolytes often saves patients from the exhaustion that accompanies prolonged diarrhea.

Lomotil acts to control the intestinal mechanisms of diarrhea; therefore, it is highly useful in controlling diarrhea associated with:

gastroenteritis · acute infections · functional hypermotility
irritable bowel · ileostomy · drug-induced diarrhea

Warnings: Lomotil should be used with caution in patients taking barbiturates and with caution, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a Federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur, signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise. Respiratory depression and coma may occur with overdosage.

Dosage. The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children:	*Total Daily Dosage*
3-6 mo.	½ tsp.* t.i.d. (3 mg.)
6-12 mo	½ tsp. q.i.d. (4 mg.)
1-2 yr.	½ tsp. 5 times daily (5 mg.)
2-5 yr.	1 tsp. t.i.d. (6 mg.)
5-8 yr.	1 tsp. q.i.d. (8 mg.)
8-12 yr	1 tsp 5 times daily (10 mg.)
Adults:	2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

G. D. SEARLE & CO.
Research in the Service of Medi
951



this ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement to facilitate healing in chronic cutaneous ulcers...

Elase® Ointment

(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

PARKE-DAVIS

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

48168



SSA Regulations For Coverage Of Injections

A recent clarification by SSA in respect to the coverage of injectable drugs responds to many requests by Physicians for information related to reimbursement for injectables. Based on this clarification, any drug which is injected and medically indicated (with the exception of insulin in non-emergency situations) is covered provided the other coverage conditions described below are met. On a prospective basis all claims now being processed will be paid in accordance with this concept. After you have read the below-described regulations, it will be apparent that reimbursement for injections has been liberalized, although specified limitations referrable to medical necessity still are in force.

Excerpts From SSA Manualized Regulations

Section 6103.1 *Drugs and Biologicals—General.*—Drugs and biologicals are covered only if (a) they are of the type that cannot be self-administered; (b) they are not excluded as immunizations; (c) they are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice; and (d) they meet all the general requirements for coverage of items as "incident to" a physician's services (i. e., the drug must be administered by the physician or by his nurse under his personal supervision and the charge, if any, for the drug must be included in the physician's bill) . . . .

A. *Whether a drug or biological is of a type which cannot be self-administered is* based on the usual method of administration of the *form* of that drug or biological as furnished by the physician. Thus, where a physician gives a patient pills or other oral medication, these are excluded from coverage since the form of the drug given to the patient is usually self-administered. Similarly, if a physician gives a patient an injection which is usually self-injected (thus far, insulin is the only drug determined to fall in this category), this drug is excluded from coverage, unless administered to the patient in an emergency situation (e. g., diabetic coma) . . . .

B. *Vaccinations or innoculations are excluded as "immunizations"* unless they are directly related to the treatment of an injury or direct exposure to a disease or condition, such as, for example, antirabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera or immune

(Continued on Page 569)

nursing care for cancer patients–

...a major concern for their families, *and* for their physicians. In a unique pioneering service, the American Cancer Society is deeply involved in finding a solution.

Recognizing the phenomenal growth of nursing homes—aware of the shortage of nurses—knowing the implications of the extended care benefits of Medicare—the Society has launched a dramatic educational demonstration project on cancer nursing for nursing home staff. Special emphasis is on colostomy irrigation, care of the laryngectomized patient, care of an ileal bladder, and emergency nursing. To achieve maximum application of this plan, a cadre of nurses is being trained by the Society to conduct cancer nursing courses in nursing homes throughout the nation.

This endeavor has been warmly endorsed by the American Nurses Association and other professional organizations. We feel sure that such a program, bringing skilled nursing care to the bedside of the cancer patient, will be enthusiastically received by the medical profession.

AMERICAN CANCER SOCIETY®



THIS SPACE CONTRIBUTED BY THE PUBLISHER

AMERICAN CANCER SOCIETY ALABAMA DIVISION, INC.

1025 SOUTH 18th STREET

BIRMINGHAM, ALABAMA 35205

(Continued from Page 567)

globulin. In the absence of injury or direct exposure, preventive immunization (vaccination or innoculation) against such diseases as smallpox, polio, diphtheria, etc., is *not covered.* (Flu injections are administered as a preventive measure and are excluded from coverage without regard to a patient's particular susceptibility to influenza).

C. *The injection must be reasonable and necessary for diagnosis or treatment of an illness or injury* in order for payment to be made. Determinations as to whether an injection is reasonable and necessary should be made on the same basis as all other such determinations—with the advice of medical consultants and with reference to accepted standards of medical practice and the medical circumstances of the individual case. Below are guidelines identifying four categories with specific examples of situations in which injections would not be reasonable and necessary according to accepted standards of medical practice. Carriers should supplement the guidelines below with guidelines concerning appropriate use of specific injections in other situations. The guidelines should be used to screen out for denial claims in which use of the injection billed for would not be reasonable and necessary, and to screen out questionable cases for special review or further development.

Where an injection is determined not reasonable and necessary for diagnosis or treatment of an illness or injury according to these guidelines, the entire charge (i. e., for both the drug and its administration) should be excluded from payment. In addition, in those situations where it comes to the carrier's attention (e. g., from a beneficiary contact) or otherwise becomes apparent that an individual physician is billing for other services (such as office visits) which were primarily for the purpose of administering a noncovered injection (i. e., an injection that is not reasonable and necessary for the diagnosis or treatment of an illness or injury), the charge for such services should also be excluded from payment.

1. *Injections not specifically indicated*—injections which are not considered by accepted standards of medcial practice to be indicated as *specific* or *effective* treatment for the particular condition for which they are given (although the injection may be accepted treatment for another illness). Professional medical advice received by the Social Security Administration concerning vitamin B-12 injections, for example, indicates that such injections would be specific therapy for pernicious anemia and other conditions in which various physiological mechanisms may result in B-12 deficiency (such as total gastrectomy, intestinal disease such as sprue and idiopathis steatorrhea, surgical and mechanical disorders such as resection of the small intestine, intestinal stric-

(Continued on Page 571)



Norflex®
(orphenadrine citrate, 100 mg.)

Takes the agony out of low back pain



Take the agony out of low back pain... Norflex® (orphenadrine citrate) relaxes the muscles in spasm.

Restore mobility and hasten recovery... prescribe Norflex 1 tablet b.i.d.

Indications: Acute spasm of voluntary muscles, regardless of location; especially post-traumatic, discogenic, and tension spasms. **Contraindications:** Due to its anticholinergic action, NORFLEX should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcer, prostatic hypertrophy or obstruction at the bladder neck, cardiospasm (megaesophagus) and myasthenia gravis. Use with caution in patients with tachycardia. Do not use propoxyphene (Darvon®) concurrently. **Adverse Reactions:** Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Adverse reactions are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported. **Dosage and Administration:** Two tablets per day for adults, regardless of weight or sex; one in the morning and one in the evening. Each tablet contains 100 mg. orphenadrine citrate.
For full information, see Package Insert or P.D.R.

Norflex®
(orphenadrine citrate)

Riker Laboratories
Div. of Dart Industries Inc.
Northridge, California 91324

The Riker representatives in your area are:
Robert Johnston
Billy J. Phillips
William O. Crabb
Paul E. Loeffler III

(Continued from Page 569)

tures, and anastomosis, fish tape worm anemia, and nutritional macrocytic anemia). However, where vitamin B-12 or any other injection is not considered by accepted standards of medical practice to be specific or effective treatment for the condition for which given, it should be excluded.

2. *Injection not for particular illness*—medication given for a purpose other than for treatment of a particular condition, illness, or injury. For example, the entire charge for vitamin injections given simply for the *general good and welfare of the* patient and not as accepted therapy for a particular illness should be excluded.

3. *Injection method not indicated*—injection is not considered an indicated method of administration according to accepted standards of medical practice for the condition for which given.

4. *Excessive injection*—medication administered for treatment of a disease which exceeds the frequency or duration of injections indicated by accepted standards of medical practice as an appropriate level of care for that condition, unless there are extenuating circumstances which justify the need for additional injections. For example, where accepted standards of medical practice indicate that vitamin B-12 injections are indicated for pernicious anemia not more frequently than at certain intervals, the entire charge for injections given in excess of these intervals should be excluded. Another example would involve the situation where standard medical practice indicates the use of parenteral penicillin or other antibiotics for the initiation of, but not for the entirety of the course of treatment for an infectious disease. In such cases, the entire charge for those penicillin injections exceeding the initial standard dosage should be excluded unless there are special medical circumstances which justify additional injections.



The Month in Washington

From the Washington Office
American Medical Association

Washington—An American Medical Association spokesman outlined the AMA's voluntary national health insurance plan, "Medicredit," for consideration by the House Ways and Means Committee.

Dr. Russell B. Roth, speaker of the AMA's House of Delegates and a practicing physician in Erie, Pa., said the plan, which would be financed in part by federal income tax credits, is flexible and would assure all Americans—no matter how limited their financial resources—of adequate health care protection.

"Representing this country's physicians as we do," Dr. Roth said, "the AMA is on record in its belief that it is the basic right of every citizen to have available to him good health care.

"Today we want to put before this committee a plan which is universal in scope, voluntary in nature, and realistic in terms of total program cost."

He estimated the program would cost the federal government $8 billion to $9 billion a year, but about $3 billion a year of that would be offset by liquidation of the medicaid program. Medicare would continue.

"For those in low-income categories, this protection is theirs without expense or contribution on their part," Dr. Roth said. "For those with moderate and higher levels of income, Medicredit provides a system of cash incentives to enable them to protect themselves against major health care costs . . .

"Our proposal is the result of years of careful study of our existing mechanisms for delivering and financing health care, coupled with our close study of the federal government's ability to fund a universal health insurance program . . .

"It would give to persons who have purchased comprehensive health insurance the option of receiving a tax credit on their annual federal income tax return, a credit based on their tax liability. That is, a taxpayer could take as a credit against the amount of income tax owed to the federal government, all or part of their personal cost for comprehensive health coverage. Persons or families with a lower tax liability (usually reflecting lower income or more dependents and allowable expenses) would receive a greater tax credit. And those families in the lower 30 per cent income range, would, without cost to them, receive a certificate enabling them to purchase health coverage from qualified groups or plans."

The AMA plan calls for establishment of a "Health Insurance Advisory Board" to create Medicredit guidelines. It would be chaired by the Secretary of Health, Education, and Welfare and include the Commissioner of Internal Revenue and public members. It would review the effectiveness of the program and file annual reports with the President and the Congress.

Basic medical benefits of Medicredit would include:

—Up to 60 days of inpatient hospital services, including maternity services;

—All emergency room and outpatient services provided in the hospital;

—All physicians' services, whether performed in the hospital, home, office or elsewhere.

Supplemental benefits to basic coverage would also be eligible for tax credits.

Dr. Roth stressed the importance of utilizing private insurance carriers, this taking maximum advantage of private sector competition to help hold costs down.

Rep. Durward G. Hall, M. D. (R., Mo.), a former member of the AMA House of Delegates submitted to the committee another national health insurance plan. The first part of his two-part plan calls for the federal government to furnish persons eligible for medicaid with health insurance certificates covering certain specified basic health protection. The states would have the responsibility for the balance of health care for an eligible individual after his basic coverage had been exhausted. Thus, the Hall plan would replace medicaid.

The second part of the Hall proposal calls for the federal government helping, in cases of catastrophic illness, those persons who can afford normal health care insurance only.

Other national health insurance plans are being sponsored by Walter Reuther, head of the automobile workers' union; the AFL-CIO; Sen. Jacob K. Javits (R., N. Y.), and Gov. Nelson Rockefeller of New York. Indications are that the committee will not give serious consideration to such legislation before next year at the earliest. However, it appears probable that the issue will come to a vote in Congress before the 1972 elections.

* * *

The AMA also submitted to the Ways and Means Committee a statement on the Nixon Administration's "Health Cost Effectiveness Amendments of 1969" legislation.

The AMA commended the Department of Health, Education and Welfare for its efforts to curtail the rising costs of medicaid and medicare, but said that the Association believes "there are better and more appropriate means of meeting this problem."

As for the provision prohibiting payment to physicians who have committed fraud, overcharged or otherwise abused the medicare program, the AMA said:

"It should be kept in mind that there presently exist remedies to reach the cases of abuse which may exist—certainly the cases of extreme abuses which HEW has asserted these proposed penalties are intended to reach. While it is true that the law does not provide authority to disqualify physicians as to prospective participation, a carrier may reject or review a physician's claims on an individual basis as each claim is presented.

"The apparent concern of the Congress regarding alleged abuses and increasing program costs may require some changes in the administration of federally financed health care programs. However, the proposed amendments appear to introduce more severe remedies than the problems require."

As for the provision that utilization review committees pass retroactively on the medical necessity of admission of medicare patients to hospitals, the AMA said:

"At the present time a utilization review plan of an institution must provide for review, on a sample basis or other basis, of admissions, duration of stays, and services furnished but must provide for review of each case of extended stay and also determine medical necessity of further stay. The law provides for 3 additional days of benefit payments after a negative finding and notification.

"Where a finding has been made that the admission was unnecessary, no payment would be made. Thus the denial of payment would be retroactive to the date of admissions. The 3-day grace period is removed from existing law.

"The AMA previously objected to initial certification of the need for admission to a hospital, and this initial certification requirement was removed from the law. Under this bill the utilization review committee would be required to review the attending physician's judgment as to the need for hospitalization. The present requirement of the committee under medicare is to review extended

stay cases to determine need for further stay; thus it does not review a great number of cases of hospitalization where the patient is discharged earlier. Requiring committees to review all cases of hospitalization would impose a tremendous burden on the committee, and create additional heavy demands on physicians' productive manhours.

"An adverse finding by a committee would subject the patient to individual liability for hospital charges. As a result, this provision could act as a restraint on patients receiving care, particularly in those cases where a physician recognizes the possibility of differing medical judgments concerning the admission."

Not just a motel
it's a Guest House

. . . with 171 handsome rooms designed for your comfort and convenience. A center-of-everything location including Birmingham's University of Alabama Medical Center . . . making The Guest House a favorite of Doctor's wives and in-town outpatients. Superb dining, dancing and nightly entertainment. Come stay with us often.

THE RESTAURANT
THE PLAYROOM • CYPRESS ROOM
CONVENTION FACILITIES



The Guest House
MOTOR INN

PHONE 324-8653
18TH ST. &
10TH AVE., SOUTH
BIRMINGHAM, ALABAMA

"Where the Action Is!"

Vividly Illustrative Of Today

The general public misses the irony of blaming doctors for rising Medicaid costs, forgetting that doctors were vigorously opposed to it despite the fact that the plan would relieve them of much free humanitarian responsibility.

Dr. Dwight L. Wilbur, immediate past president of AMA, estimating that Medicaid costs in five years may rise to $12 to $16 billion, offers the following suggestions:

1. Substitute a less costly rest home for the nursing home for many patients, and expand out-patient care.

2. Encourage local medical societies to be more vigilant in policing instances of unwarranted abuse of the program by some doctors.

3. Have organized medicine plan and direct facilities to provide more health care in underprivileged areas.

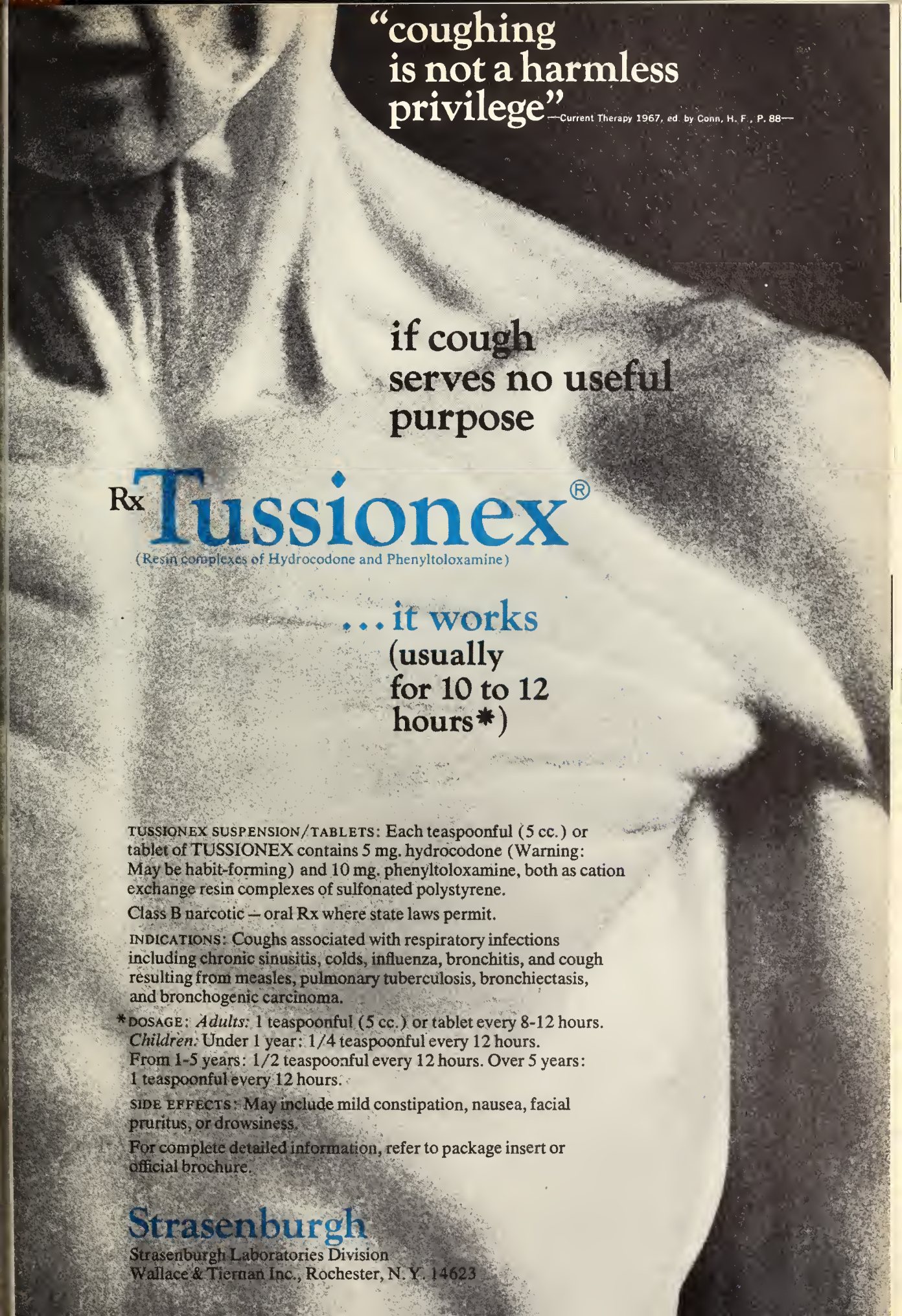
4. Encourage medical societies to oversee promotion of cost efficiencies while maintaining quality health care.

5. Let the public know about it.

Nobody To Talk To

Ann Landers, author of the world's most widely syndicated column and a member of the AMA's Advisory Committee on Health Care, was guest speaker at a New York luncheon, declaring that "lack of communication is the biggest problem of marriage today. The most common complaint of women is that they don't have anyone to talk to." Turning to youth today, she said: "The problem with teens is that they have the disadvantage of having too many advantages, whereas their parents were teens during the depression and had to work hard just to survive; the problem of teens today is how to get them off their behinds."

—Ohio State Medical Journal



TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic – oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

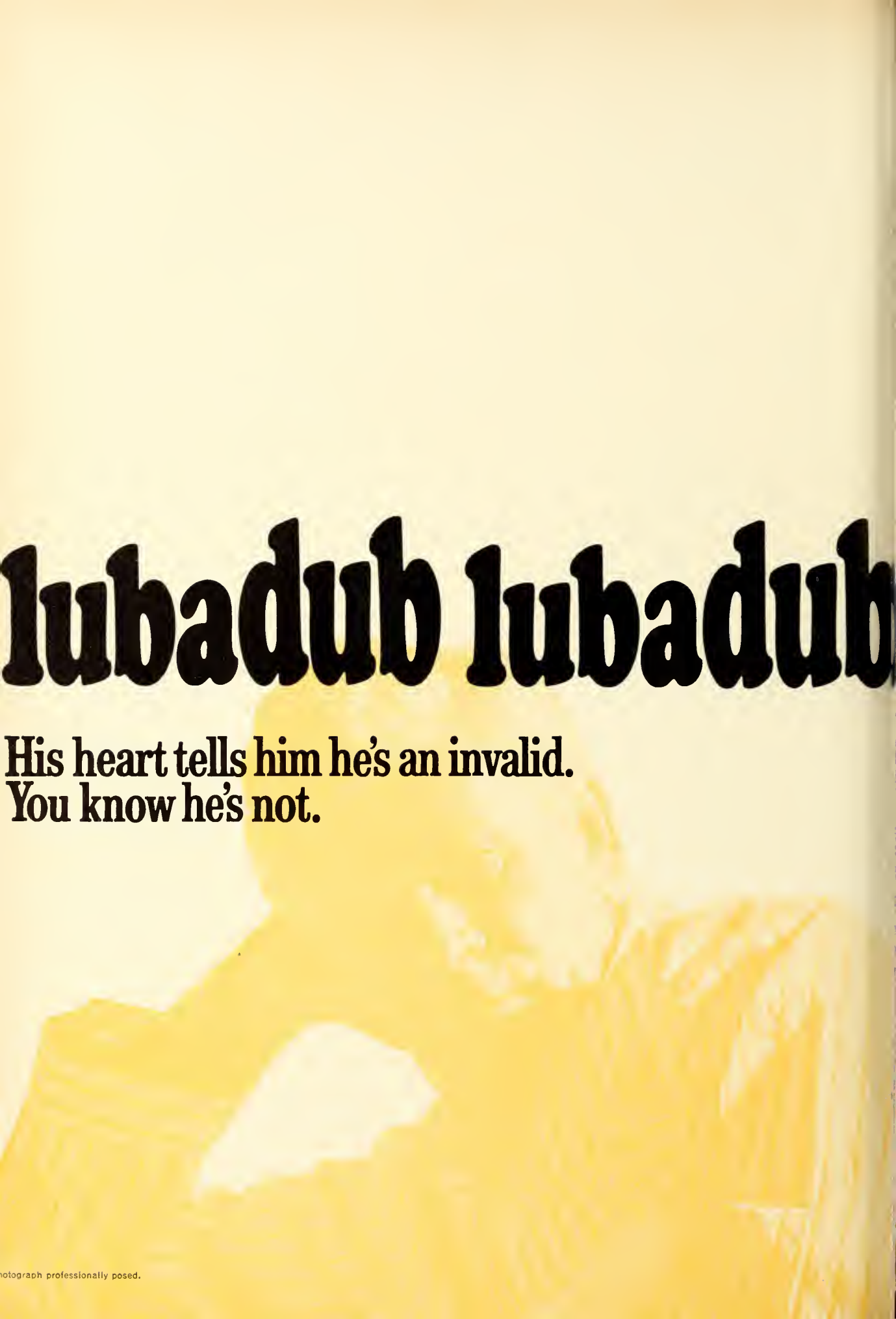
For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y. 14623

lubadub lubadub

His heart tells him he's an invalid.
You know he's not.



hotograph professionally posed.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

Equanil®
(meprobamate) Wyeth

badubdub lubadi

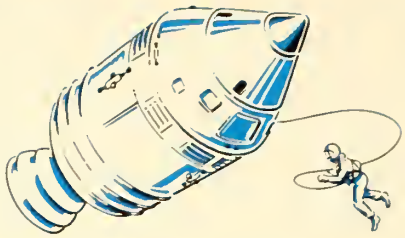
xiety is expected in the cardiovascular patient.
ittle may even be desirable.

t when anxiety is exaggerated . . . when it
erferes with sleep . . . when it aggravates
rdiovascular symptoms, your help may
needed.

turally, you'll want to reassure the patient.

d perhaps prescribe Equanil (meprobamate)
adjunctive therapy. It helps relieve anxiety
d tension specifically, yet gently.

most 15 years' use has shown that Equanil
usually well tolerated as well as effective.
de effects are generally limited to transient
bwsiness; serious, therapy-interrupting
le effects are rare.



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals



around the state

New Physicians Licensed To Practice In Alabama



Earl Bennett Barron, M. D., Albert Einstein College of Medicine, 1965, Reciprocity with National Board of Medical Examiners—Intends to locate in Montgomery (Maxwell AFB).



Linwood Gray Bradford, M. D., Medical College of South Carolina, 1965, Reciprocity with South Carolina—Intends to locate in Birmingham.

Peter Choate Booher, M. D., Emory University School of Medicine, 1966, Reciprocity with Georgia—Intends to locate in Birmingham.

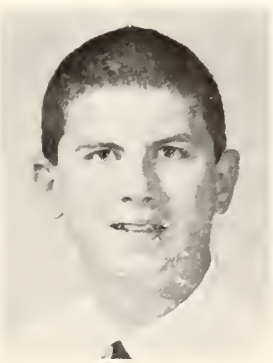


Harvey Guy Coker, Jr., M. D., University of Tennessee College of Medicine, 1953, Reciprocity with Tennessee—Intends to locate in Birmingham.

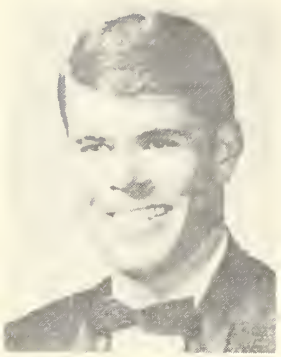




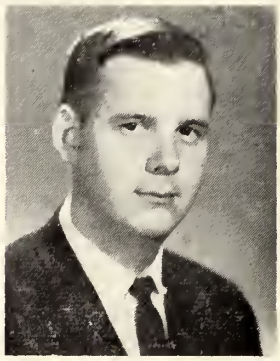
Marshall Lee Brewer, M. D., Loma Linda University, 1968, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Francis Hammond Cole, Jr., M. D., University of Tennessee College of Medicine, 1968, Reciprocity with Tennessee—Intends to locate in Florala (USN, Pensacola).

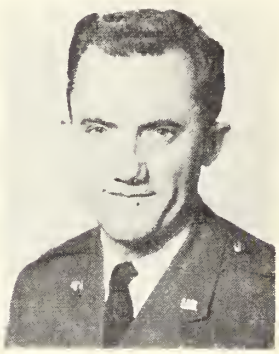


Ellis Phillip Couch, M. D., Baylor University School of Medicine, 1968, Reciprocity with Texas—Intends to locate in Huntsville, Alabama.



Frederick Emerson Gilbert, Jr., M. D., Medical College of Alabama, 1968, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.

Hugh Adair Cox, M. D., University of Kansas School of Medicine, 1959, Reciprocity with Kansas—Intends to locate in Montgomery (Maxwell AFB).



David Goldblatt, M. D., University of Louisville School of Medicine, 1967, Reciprocity with Kentucky—Intends to locate in Selma.





William Ernest Dismukes, M. D., Medical College of Alabama, 1964, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



Thomas Arthur Haedicke, M. D., Wayne State University School of Medicine, 1943, Reciprocity with Michigan—Intends to locate in Montgomery.

Robert Newell Finchum, M. D., University of Tennessee College of Medicine, 1960, Reciprocity with Tennessee—Intends to locate in Birmingham.



Donald Wayne Hegge, M. D., University of Washington Medical School, 1963, Reciprocity with National Board of Medical Examiners—Intends to locate in Montgomery (Maxwell AFB).



(Continued on Page 584)

fast start on a short therapeutic course



Sterazolidin®

50 mg. phenylbutazone
1.25 mg. prednisone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

Prompt anti-inflammatory action for...
relieving pain and stiffness
reducing tenderness and swelling
restoring joint movement
in bursitis, synovitis, tenosynovitis
and acute fibrositis.

Total treatment time: 7 days
Usual dosage: 2 capsules t.i.d.

terazolidin is valuable in the treat-
ient of acute rheumatic conditions so
ften refractory to routine therapy.
owever, it is a potent drug, not a simple analgesic. Therefore, Stera-zolidin should never be administered casually. For complete details on dosage, adverse reactions, contrain-dications and precautions, please see the following two pages.

Sterazolidin®

Each capsule contains:

Butazolidin®, brand of phenylbutazone	**50 mg.**
prednisone	**1.25 mg.**
dried aluminum hydroxide gel	**100 mg.**
magnesium trisilicate	**150 mg.**

Antiarthritic
Anti-Inflammatory

Capsules

Important Note Butazolidin, brand of phenylbutazone, and prednisone, the active ingredients of Sterazolidin, are both potent drugs; the pharmacologic action of each should be borne in mind when Sterazolidin is prescribed. Sterazolidin combines anti-inflammatory, analgesic, antipyretic, and antiallergic properties and cannot be considered a simple analgesic and should never be administered casually. The usual warnings, precautions and contraindications associated with Butazolidin, brand of phenylbutazone, therapy and steroids apply to Sterazolidin.

Indications: *Chronic treatment of:* rheumatoid arthritis, rheumatoid spondylitis, osteoarthritis; and also treatment of acute rheumatic conditions such as bursitis, synovitis, tenosynovitis, various forms of acute fibrositis, and acute gouty arthritis.

Contraindications
Usually absolute: active, questionably healed or suspected tuberculosis, herpes simplex ophthalmia, acute psychoses or severe psychoneuroses, history of blood dyscrasia, the frankly senile patient, and active peptic ulcer.

Relative: exanthematous diseases, particularly varicella and fungal diseases (for other viral diseases, the physician must weigh the possible undesirable effects against anticipated clinical improvement), diverticulitis, recovery phase after gastrointestinal surgery, any condition complicated by cardiovascular disease, renal insufficiency, moderate or severe diabetes mellitus, thrombophlebitis, osteoporosis, convulsive disorders, thyroid disease, history of drug allergy, history of peptic ulcer, hypertension, the elderly patient, psychotic tendencies, pregnancy, except in severe disease (the safety of Sterazolidin in pregnancy has not been established), edema, and hepatic damage.

Its use in conjunction with other potent chemotherapeutic agents may greatly increase the possibility of toxic reaction, and this practice is, therefore, inadvisable. Large doses are contraindicated in patients with glaucoma.

Warning Coumarin-type anticoagulants depress prothrombin activity. This is accentuated in some cases when Butazolidin, brand of phenylbutazone, is simultaneously employed in treatment; occasional instances of severe bleeding have been reported. Patients receiving coumarin-type anticoagulants should be very carefully followed for evidence of excessive increase of prothrombin time when Sterazolidin is added to this regimen. Anticoagulant therapy can then be properly adjusted, if necessary. When prescribed alone, Sterazolidin has not been shown to influence prothrombin activity. Persistent or severe dyspepsia may be indicative of peptic ulceration. In these instances, upper gastrointestinal x-ray diagnostic tests should be performed if the drug is continued. Pyrazole compounds, such as phenylbutazone, may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Patients receiving such concomitant therapy, therefore, should be carefully observed for this effect.

Precautions and Adverse Reactions *Gluco-Corticoid Activity:* In some diabetic patients on prednisone, the insulin requirements may be increased. It is advisable to observe diabetic patients carefully during the treatment period. Since gluco-corticoids may unmask latent diabetes, all patients should be observed for this effect.

Electrolytes: Many patients receiving prednisone in average amounts show some loss of sodium, with little or no loss of potassium. With continued high dosage, however, sodium retention and potassium loss have been observed. Butazolidin, brand of phenylbutazone, has a definite tendency to produce sodium retention and hence, edema, particularly in the older age group. Elderly patients or those with hypertension, cardiac defect or renal dysfunction should therefore use Sterazolidin with special caution and the drug should be discontinued if edema develops. Developme of edema may be prevented or minimized withholding salt from the diet. Sodium ret tion may be counteracted with oral diureti

Nitrogen: With the recommended dosage Sterazolidin, the possibility of nitrogen los remote. However, it is recommended that tients receive adequate protein in their die Osteoporosis or spontaneous fractures ma occur with prolonged use of prednisone.

Gastrointestinal Tract: Clinical and anima studies do not indicate that the ulcerogeni activity of prednisone or Butazolidin, bran phenylbutazone, is enhanced in the combi tion. To overcome gastrointestinal discom and occasional eructation in sensitive pati the medication is best taken at mealtime o with milk; Sterazolidin contains antacid co ponents to minimize the incidence of gastr complaints. All patients should be warned report immediately the occurrence of blac tarry stools. The development of anemia sh immediately suggest gastrointestinal bleed

Blood Elements: Patients receiving predni exhibit an eosinophil response similar to th seen with other steroids. During the initial weeks of treatment, Butazolidin, brand of phenylbutazone, usually causes some deg of hemodilution and resultant lowering of t red cell count. This phenomenon does not represent a true anemia and is not indicati of intolerance, but must be distinguished fr true anemia secondary to gastrointestinal bleeding or other causes. With the extensi use of Butazolidin, brand of phenylbutazon rare cases of agranulocytosis have occurr (ratio less than 1 per 200,000 patients). It should also be noted that agranulocytosis occur suddenly in spite of regular, repeate normal white counts. Several cases of leukemia and leukemoid reactions have been reported with Butazolidin, brand of phenyl butazone, therapy. Although these reactior cannot be definitely attributed to this drug, possibility of a causal relationship cannot excluded. It should also be recognized that arthritic-type pains are sometimes the pres ing symptom of leukemia. Accordingly, all patients receiving Sterazolidin should have

It's aggressive against acute arthritic pain and inflammation.



And, we want you to know all about it

e periodic blood counts before and
therapy. Any unexpected, significant
e in the total white count, relative de-
in granulocytes, or appearance of
ure forms should be regarded as a signal
mediate cessation of therapy and institu-
appropriate countermeasures. Thrombo-
enic purpura and aplastic anemia must
e considered possible side effects of
with Butazolidin, brand of phenyl-
ne.

Surgery: Prolonged use of prednisone
ause a potentially critical degree of
cortical insufficiency which may persist
fter cessation of prednisone therapy.
ore, if a patient is subjected to signifi-
tress, such as surgery or trauma, either
Sterazolidin therapy or within one year
essation of therapy, it is advisable to
ister additional steroid and/or ACTH for
ration of the stress. Delayed wound
g may also occur in patients on pro-
l therapy.

ons: High or prolonged doses of
sone interfere with the usual immune
nisms against bacterial and viral infec-
nd may promote their dissemination. In
al, steroid treatment should not be given
presence of infections unless appropri-
tibiotic therapy is instituted at the same
systemic and localized infection compli-
s during hormone therapy have been ob-
, including fulminating pneumonia,
ulosis, moniliasis and aspergillosis.
l intercurrent infection develop, indi-
antibiotic therapy must be initiated
tly. Every patient who is to receive
olidin for any length of time should be
ghly examined, including chest x-ray,
presence of pulmonary or extrapulmo-
berculosis.

nal Imbalance: Gluco-corticoids, in pro-
l dosage, may cause manifestations of
ortisonism or Cushing's syndrome, such
onface, abnormal fat deposits, mental
ances, muscle weakness and atrophy,
ous striae, acne, ecchymoses, hirsutism,
ual disturbances, edema, osteoporosis
ontaneous fractures, and hypertension.
y suppressing adrenocortical function,
c prednisone therapy may cause some
of atrophy of the adrenal glands. There-
Sterazolidin is to be discontinued, the
l dosage should be tapered off gradu-
ally. In addition, it may be advisable to stimulate the adrenal glands with ACTH. Prednisone induces a prompt decrease in the urinary 17-ketosteroids. Pretreatment levels are usually regained within 7 to 14 days after cessation of therapy. Under conditions of long-term administration, a small percentage of patients on phenylbutazone may develop varying degrees of reversible thyroid hyperplasia.

Allergic Response: Development of drug rash should alert the physician to promptly discontinue the drug. The presence of prednisone in Sterazolidin may reduce the degree of allergic response; nevertheless, the same cautious attitude must be preserved with Sterazolidin as with Butazolidin, brand of phenylbutazone, if allergic manifestations occur. Other adverse reactions that have been observed with glucocorticoid therapy include: excessive appetite and weight gain, hyperidrosis, pigmentation, dry,scaly skin, thinning scalp hair, tachycardia, thrombophlebitis, headache, neuropathy (including paresthesias and neuritis), diffuse vasculitis similar to periarteritis nodosa, subcapsular cataracts, impaired renal function, lupus erythematosus-like changes, convulsions, insomnia, abdominal distention, aseptic necrosis of the femoral head, acute pancreatitis and ulcerative esophagitis.

Miscellaneous: Stomatitis and, rarely, salivary gland enlargement occasionally require the interruption of treatment with Butazolidin, brand of phenylbutazone. Adoption of a lower dosage schedule and the institution of strict oral hygiene sometimes prevent recurrence of lesions. The infrequent occurrence of such subjective sensations as vertigo or languor during therapy with Butazolidin, brand of phenylbutazone, is seldom a serious or significant complication. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis and jaundice, hypersensitivity angiitis, pericarditis and several cases of anura and hematuria. Patients should be carefully evaluated before treatment is started and those receiving Sterazolidin must remain under close medical supervision to guard against undesirable reactions such as those described. They should be instructed to report immediately the occurrence of fever, sore throat, lesions in the mouth, or black or tarry stools. It is recommended that periodic examinations of the patient include:

1. Verbal and physical examination, including blood pressure and appraisal of the cardiovascular, digestive and skeletal systems, for indications of toxic reaction.
2. Complete blood count (at weekly intervals during the first month), urinalysis, x-ray and electrolyte studies, as indicated.
3. Check of patient's weight to detect significant water retention.

Dosage Dosage should be individualized. The following general rules should be observed:

In acute therapy, dosage *should not exceed* 12 capsules on the first day and 6 to 8 capsules on succeeding days. Treatment for more than 7 days is rarely necessary. When therapy extends beyond one week, dosage should not exceed 6 capsules a day.

In chronic therapy, dosage *should not exceed* 6 capsules a day and should be tapered off gradually to establish the minimum maintenance level at which the patient still feels reasonably comfortable. A trial period of one week of therapy is considered adequate to determine the therapeutic effect of the drug. In the absence of a favorable response, therapy should be discontinued.

When switching from chronic high steroid therapy to Sterazolidin, the importance of gradual reduction of steroid dosage cannot be overemphasized. It should be kept in mind that the steroid content of 8 capsules of Sterazolidin will replace 10 mg. of prednisone (or its equivalent in related steroids).

Clinical experience indicates that most patients with rheumatoid arthritis may eventually be maintained on 3 to 6 capsules of Sterazolidin a day. It is advisable to administer the total daily requirement in divided doses.

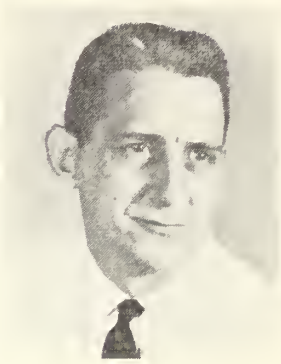
Availability Sterazolidin: Light blue and orange capsules, in bottles of 100 and 1000.
(B)46-660-B

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502



(Continued from Page 580)



Robert William Heidepriem, D. O., College of Osteopathic Medicine & Surgery, 1963, Reciprocity with Iowa—Intends to locate in Alexander City.



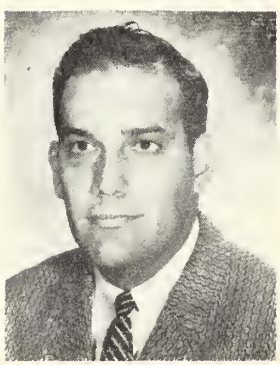
Everett Cole Mosley, M. D., George Washington University School of Medicine, 1957, Reciprocity with Georgia—Intends to locate in Huntsville.



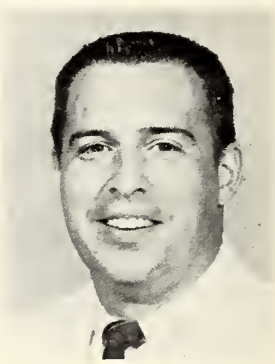
Jack Hopkins Henry, M. D., University of Texas Medical Branch (Galveston), 1964, Reciprocity with National Board of Medical Examiners—Intends to locate in Montgomery (Maxwell AFB).



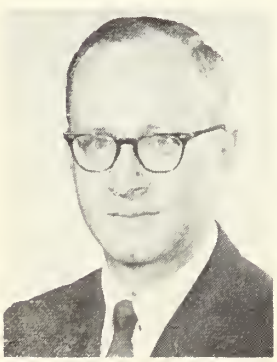
Luke Waldrep Nabers, M. D., University of Cincinnati College of Medicine, 1924, Reciprocity with Florida—Intends to locate in Red Bay.



Harlan Gary Lebow, M. D., University of Miami School of Medicine, 1962, Reciprocity with National Board of Medical Examiners—Intends to locate in Decatur.



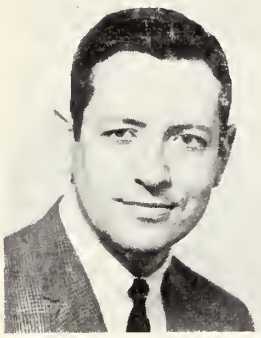
James Conrad Pierce, M. D., Louisiana State University School of Medicine, 1968, Reciprocity with Louisiana—Intends to locate in Mobile.



Emmanuel Mesel, M. D., University of Cincinnati College of Medicine, 1959, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham (Mountain Brook).



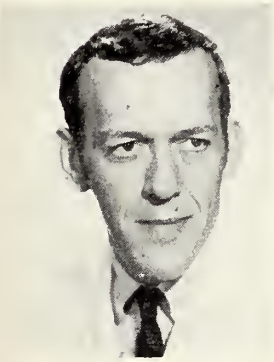
James Letcher Rollins, M. D., University of Tennessee College of Medicine, 1962, Reciprocity with Tennessee—intends to locate in Birmingham.



Hugh Maurice Shingleton, M. D., Duke University School of Medicine, 1957, Reciprocity with North Carolina—Intends to locate in Birmingham.



Robert George Wallace, M. D., University of Cincinnati College of Medicine, 1965, Reciprocity with Ohio—Intends to locate in Tuskegee.



Dyrc Frederick Sibrans, M. D., Medical College of South Carolina, 1964, Reciprocity with South Carolina—Intends to locate in Decatur.



Leonard Howard Wurman, M. D., Tufts University School of Medicine, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Pensacola (serving in Navy).



Edward Sutton Snyder, M. D., Georgetown University School of Medicine, 1965, Reciprocity with New Jersey—Intends to locate in Birmingham.



Gayle Frances Wurzlow, M. D., Louisiana State University School of Medicine, 1965, Reciprocity with Louisiana—Intends to locate in Ft. Rucker.



Franklin Julian Star, M. D., University of Chicago School of Medicine, 1958, Reciprocity with Georgia—Intends to locate in Phenix City.

Muscles Control Artificial Arm

An artificial arm having six movements, which may be operated by electric impulses derived from muscle contraction, has been created by an Israeli engineer. Lightweight, gas-powered, it was described as a "marked advance" in rehabilitation medicine at a press conference at the Institute of Rehabilitation Medicine of the New York University Medical Center.

Dr. Dino Bousso of the Technion-Israel Institute of Technology (Haifa, Israel), who developed the 13-ounce arm, said the limb's "weight, simplicity and evenness of motion" are among its unique features.

Syphilis in General Retreat Over State of Alabama

Every licensed physician in the State of Alabama is in receipt of a letter from Frederick S. Wolf, M. D., announcing a reduction in the reported cases of syphilis for the fourth consecutive year. Reported primary and secondary syphilis has been reduced 73 per cent since 1965, he said.



DR. WOLF

Dr. Wolf, who is Director of the Bureau of Preventable Diseases, accredits the astonishing achievement to the "team effort of Alabama Private Medicine and the Alabama Department of Public Health Venereal Disease Program . . . To continue the decrease in reported syphilis requires this continued cooperation and more rapid epidemiology."

Dr. Wolf's open letter added:

"The acquisition of additional darkfield microscopes and the training of technicians has been accomplished. As a result, darkfield microscopy is available to all Alabama clinicians by calling collect Montgomery 269-7610 from 8:00 a. m. to 5:00 p. m. The technician will be dispatched to your office immediately. A darkfield "POSITIVE" is diagnostic for syphilis even though the serology is negative. Every suspicious penile, vaginal, oral, and rectal lesion is deserving of darkfield microscopy before therapy is initiated."

For Darkfield Services, any physician in the state may call, during normal work days, Montgomery 269-7610 **collect**, between 8:00 a. m. and 5:00 p. m. After 5:00 p. m. and on weekends and holidays, the collect call should go to Montgomery 269-6011.

How To Become A Centenarian

Of recent years physiologists have bestowed much attention on centenarianism, but only to find how elusive the problem is. Race does not solve it, nor climate, nor heredity, nor even careful living. Centenarianism is to be met with everywhere, and under the most diverse conditions. A scientific investigation of authentic cases, however, has proved that plain living, fresh air, recreation, and abstinence from strong drink and tobacco are important causes of the extreme prolongation of human life.

Adam, when he pleaded with Orlando to be allowed to become his servant and feared rejection on the ground of age, had the root of the matter in him.

Though I look old, yet I am strong and lusty;

For in my youth I never did apply

Hot and rebellious liquors in my blood,

Nor did not with unbashful forehead woo

The means of weakness and debility;

Therefore my age is as a lusty winter,

Frosty, but kindly.

But if we do not know all the factors that make for an abnormally long life, and find it impossible to fix the relative values of those that are ascertainable, it is at all events open to us to study the lives of centenarians that have been publicly recorded, in order to discover what manner of men they were, how they lived, and worked, and passed the allotted span without the eye becoming dim or the natural force abated. By following their precepts, and taking stock of their habits, we, too, perchance, may live to the proverbial green old age, conditionally, of course, that we start the race of life with a sound constitution, and run it under circumstances similar to theirs—two not unimportant qualifications.

—W. Forbes Gray: Five Score, 1931
Republished in Minnesota Medicine



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.



Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic /antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS. Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS. Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

PRECAUTIONS: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and toler-

or here.



Though generally not recommended, if ation therapy with other psychotropics indicated, carefully consider individual cologic effects, particularly in use of po- ng drugs such as MAO inhibitors and iazines. Observe usual precautions in e of impaired renal or hepatic function. xical reactions (*e.g.*, excitement, stimula- d acute rage) have been reported in psy- patients. Employ usual precautions in nt of anxiety states with evidence of im- ; depression; suicidal tendencies may be and protective measures necessary. Vari- fects on blood coagulation have been d very rarely in patients receiving the nd oral anticoagulants; causal relation- s not been established clinically.

ERSE REACTIONS: No side effects or tations not seen with either compound ave been reported with Librax. When izepoxide hydrochloride is used alone, ess, ataxia and confusion may occur, ly in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE
ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110


No place for beginners

Terramycin®
(oxytetracycline)

An infection of rapid onset requiring prompt attention. Teenage girl with chills, fever, abdominal pain, backache and nausea. Frequent and urgent urination with burning. On examination—tenderness over kidney. Blood count and urinalysis confirm the diagnosis: acute pyelonephritis. Treatment is initiated with Terramycin. Within a few days of follow-up therapy, the patient is markedly improved. The pretreatment urine culture shows a strain of *E. coli* highly susceptible to Terramycin.

Experience has shown that Terramycin offers special advantages in treating urinary tract infections when strains of causative bacteria are susceptible. Broad-spectrum coverage unaffected by penicillinase. Effective tissue levels to help reach foci of infection in renal parenchyma. High urine levels—excreted by kidney in *active* form.

With Terramycin, you have the assurance that comes with choosing an agent physicians have depended on for over 18 years. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Contraindicated: In individuals hypersensitive to oxytetracycline.

Warnings: Reduce usual oral dosage and consider antibiotic serum level determinations in patients with impaired renal function.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight; if such reactions occur, discontinue therapy.

Note: With oxytetracycline, phototoxicity is unknown and photoallergy very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy. Increased intracranial pressure in infants is a possibility. Symptoms disappear upon discontinuation of therapy.

Adverse Reactions: Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.

Supply:* Terramycin Capsules: oxytetracycline HCl, 250 mg. and 125 mg. Terramycin Syrup: calcium oxytetracycline, 125 mg. per 5 cc. Terramycin Pediatric Drops: calcium oxytetracycline, 100 mg. per cc.

*All potencies listed are in terms of the standard, oxytetracycline.

More detailed professional information available on request.



Terramycin®
(oxytetracycline)

Pfizer LABORATORIES DIVISION
New York, N.Y. 10017

Three Mobile Doctors Develop Brush Biopsy Technique

Dr. James K. V. Willson, Mobile Radiologist, was awarded the Silver Medal by the American Roentgen Ray Society at its annual meeting in Washington, D. C., for his presentation of "A Guided Brush for Bronchial Brush Biopsy."

This exhibit presented a new system for bronchial brush biopsy using a controllable brush that can be directed into any desired bronchus. Co-authors were Dr. Marshall Eskridge, Radiologist, Mobile Infirmary, who assisted Dr. Willson in the development of this new instrument, and Dr. Edwin L. Scott, Pathologist, also of the Mobile Infirmary.

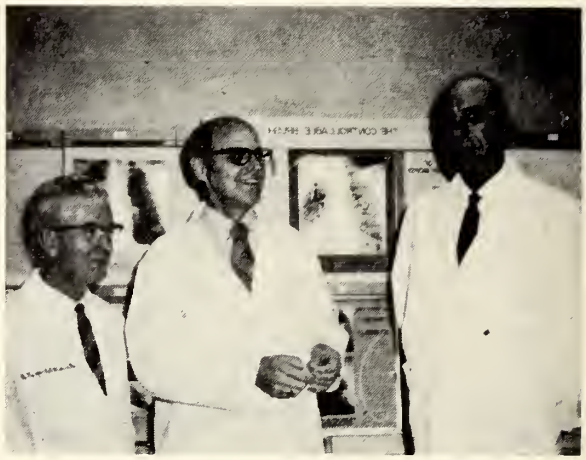
"The control feature of the brush," Dr. Willson said, allows it to be manipulated to prevent binding against the wall of the bronchus, and also allows it to be directed into the various bronchial branches beyond the tip of the catheter.

"To date, we have performed 101 examinations. There were 41 bronchogenic carcinomas (cancerous tumors in the bronchial branches). A positive brush biopsy (examination and removal of tissue) was obtained in 35. There have been no complications and our pathologist has reported no false positives.

"Small size and peripheral location are not limiting factors for this procedure. We have brushed. The average time to perform the every segment of every lobe. There have been several small peripheral coin lesions. The smallest was a 7 mm. lesion in the periphery of the right lower lobe, superior segment.

"With this technique, any visible lesion anywhere in the bronchial tree can be brushed. The average time to perform the complete study is about one hour."

As Dr. Willson described the technique, first a soft catheter is inserted through the patient's nose or mouth and through this is inserted over the guide wire and directed to the proper bronchus. The guide wire is removed and the brush inserted. The brush is then turned to pick up cells and tissue, which are removed for examination.



DRS. SCOTT, WILLSON, ESKRIDGE

'The Liberty To Die'

"As one observes the long years of suffering of loved ones and of old friends," says a terse item in The Journal of the Iowa Medical Society, "or sees the vacuous faces of the aged and the senile in a nursing home awaiting the blessing of eternal rest, one recalls a little poem by Emily Dickinson. It expresses so very well the feelings of physicians as they minister to those wracked with pain or suffering from anguish and despair:

"The heart asks pleasure first
And then the excuse from pain
And then, those little anodynes
That deaden suffering
And then, to go to sleep
And then if it should be
The will of its Inquisitor
The liberty to die."

Books of Interest to Doctors and Patients

THE VIEW FROM A HIGH BED, by Max Hampton, The Bobbs-Merrill Company, Indianapolis and New York, 217 pages—$5.95.

The public relations chief for one of the great hotel chains in the world, who wrote a best seller some years ago under the title, *Throw Away the Key*, was shocked three years ago with the discovery that he had a lung cancer. This is his book about that experience—a guide for his fellow hopeful, almost happy, patients.

"When the gods wish to punish us, they answer our prayers," Oscar Wilde wrote three quarters of a century ago. The flip side of that philosophy, Hampton's book observes, is: "When the gods are truly annoyed, they permit our fears to come to pass."

What happened to Hampton in 1966 is the realized fear of every smoker in the civilized world today.

You'd think there is almost nothing funny about a lung cancer. But what there is about it, about the hospital, and about the dialogs that echo through the hospital corridors, pack themselves into a rewarding book that any patient will find helpful—even a lung cancer patient.

—W. J. Mahoney, Jr.

NATIONAL FIRE CODES, Vol. 4 (Building and Construction Facilities), National Fire Protection Association, Boston, viii + 732 pages—$5.

This is one of ten volumes in the ninth edition of National Fire Codes, presenting 202 separate standards in 7,762 pages, the set priced at $40.

Vol. 1 is "Flammable Liquids," Vol. 2 "Gases, Ovens and Boiler-Furnaces," Vol. 3 "Combustible Solids, Dusts and Explosives," Vol. 5 "Electrical," Vol. 6 "Sprinklers, Fire Pumps and Water Tanks," Vol. 7 "Alarm and Special Extinguishing Systems," Vol. 8 "Portable and Manual Fire Control Equipment," Vol. 9 "Occupancy Standards and Process Hazards," and Vol. 10 "Transportation."

Vol. 4 was chosen for review here because it includes the important Life Safety Code, Lightning Protection Code, a glossary of heating terms, air conditioning, heating, ventilating and exhaust systems; fire tests for building materials and components, plus new standards on incinerators and on commercial cooking equipment.

The books are uniformly bound in a heavy paper in the colors red, white and blue. They are a valuable reference for many that should be available in libraries of the larger cities.

—W. J. M., Jr.

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472:9

Fathers and Sons in Medicine

Six Jordans In Three Generations

Six members of a single family, ranging across three generations and across the State from Madison County to Baldwin, have practiced medicine in Alabama in the 20th Century. The name is Jordan, pronounced like the river in Palestine rather than the lake in Alabama's Black Belt.

The first of the six was James S. Jordan, born in Butler County, near Greenville, on St. Patrick's Day, 1881. Completing his public-school education, he taught for seven years before beginning his higher education at Southern University, Greensboro, continuing work on his baccalaureate at the University of the South, Sewanee, Tenn., and completing work on his M. D. degree at Memphis Medical College, graduating in 1912.

He taught school for another year to earn the price of a horse and buggy and medical supplies, beginning practice in 1913 in the Aiken community, Crenshaw County; moving in 1916 to Industry, near Greenville, where he practiced until 1934, when he made his final move to McKenzie, where he practiced until his death June 27, 1961.

His brother, Henry W. Jordan, born in Butler County, was five years his junior, but received his M. D. degree in the same year, 1912. The younger Dr. Jordan practiced medicine in Lowndes and Covington Counties for 11 years before moving to Baldwin in 1923. Three years after that he moved from Foley to Robertsdale where he remained until his death on a Sunday afternoon in March, 1950. Quite in keeping with his profession, this Dr. Jordan was attending a patient when he dropped dead.

The latter Dr. Jordan's son, Henry Claudius



James S.



Henry W.



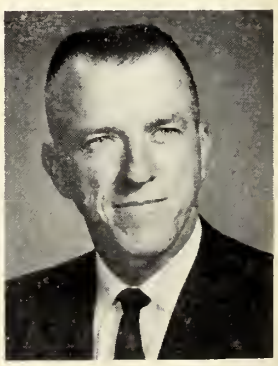
Henry C.



Henry D.



William S.



Burtis B.

Jordan, M. D., had been practicing with his father for a decade before his death. Born in Sewanee, Tenn., July 6, 1908, he received his public school education in Baldwin County before continuing to the University of Alabama for his baccalaureate and Master's degrees, going on to L. S. U. for his M. D., 1934. He interned at Charity Hospital, New Orleans.

Dr. Henry Claudius Jordan established the Jordan Clinic in Fairhope in 1940, and this clinic served as the area's only hospital until the opening several years ago of the Thomas Hospital, on the staff of which he served until his death Aug. 4, 1969. Survivors:

His widow, the former Mary R. Sailor of Colfax, Ill.; a daughter, Miss Claudia Jordan, Warrington, Fla.; two sons, Henry D. Jordan, M. D., Rochester, Minn.; William S. Jordan, M. D., Meridian, Miss.; a sister, Mrs. Marvell Jordan Gwaltney, Robertsdale; a brother, J. Wilbert Jordan, Mobile; and two grandchildren.

Henry Davidson Jordan, elder of the two sons of Dr. Henry Claudius Jordan, was born June 4, 1940, in Mobile and attended Fairhope High School, where he was elected to the Beta Club and the National Honor Society; received his baccalaureate from Birmingham-Southern in 1962 (a member of the Theta Chi social fraternity and the Theta Chi Delta honor chemistry fraternity); graduating with his M. D. degree from Emory in 1966. He interned at Emory and V. A. hospitals in Atlanta.

Entering the Navy in July, 1967, he served as Battalion surgeon with the 3rd Marine Division, FMF, in Vietnam, and later as general medical officer at Treasure Island Naval Station, San Francisco. He is currently a first year resident in internal medicine at Mayo Graduate School of Medicine, Rochester, Minn.

William Sailor Jordan, the second son, was born Aug. 22, 1941, in Fairhope, attended the Fairhope public schools and at graduation time was in a four-way tie for Valedictorian of his class of 1959. He was awarded honorable mention in the Alabama state talent search for the General William Crawford Gorgas scholarship. He was graduated *cum laude* from Vanderbilt, receiving the Underwood Memorial award in his major, Biology. His M. D. degree was from Vanderbilt also, dated 1967. He had completed one year of residency at Indiana University Medical Center when he was called to active duty, and is presently stationed as general medical officer at the Naval Air Station, Meridian, Miss.

Dr. William S. Jordan was married in 1964 to Karen Lea Kilts of Tullahoma, Tenn., a graduate of Peabody College, and they have two sons, Christopher, 2 years old, and David, 6 months.

And finally, returning to the eldest member of the three generations of Jordans in Medicine, Dr. James S. Jordan's son is Bertis B. Jordan, born at Industry, Ala., on Nov. 14, 1925. After graduating from McKenzie High School, he interrupted his education for four wartime years of service in the U. S. Navy, then attending the University of Alabama, from which he received his baccalaureate degree in 1949, his M. D. in 1954. He interned and had a two-year residency in surgery in Mobile General hospital before beginning practice in Huntsville in July, 1957, where he remained 12 years, moving the past summer to Gulf Breeze, a suburb of Pensacola, Fla.

Married to the former Dorothy Huggins of McKenzie, the Jordans have twin sons, Ricky and Randy, age 14 (and quite possibly doctors for another generation of Jordans), and two daughters, Jill, 13, and Jennifer, 9.

Dr. Jordan's two hobbies, fishing and boating (which may account in a large measure for his removal from inland Huntsville to coastal Gulf Breeze), are supplemented by woodworking. This Dr. Jordan, by the way, was 8th District Director for ALAPAC until his move to Florida.

Immediate Past MASA President And His Father

"Cases of pellagra that are not treated can lead to insanity."

That direct quote from a popular reference work explains why a psychiatrist from the early days of this century, who began his practice in 1905 at Searcy Hospital in Mount Vernon, won a special Citation for his research on Pellagra from the Medical Association of the State of Alabama.

It was research done in 1907-09, some years before the birth of his son, Emit Luther McCafferty, Jr., M. D., immediate past President (1968) of this same Medical Association.

The senior Dr. McCafferty, born in Carrollton, Pickens County, received his baccalaureate degree from Southern University, Greensboro, and his M. D. from Emory. He was married seven years after his arrival at Mount Vernon to a Mobilian, Rose Elizabeth Thompson, and two children were born to them, a daughter, Marion Elizabeth, who is today Mrs. Edwin B. Sparkman, and their son whose birthday is Nov. 17, 1914.

Beginning with the practice of psychiatry at Mount Vernon, Dr. McCafferty became that institution's Superintendent several years later, and continued in that capacity until his death in Mobile the day before his birthday, Jan. 14, 1946. The Citation for his research in pellagra was awarded him by MASA July 15, 1939.

The father did not live to see his son follow him into the practice of medicine.

Born at Mount Vernon, destined to be known through life by his intimates as "June," the son was graduated from the University Military School, Mobile, 1932; received his baccalaureate from the University of Alabama, 1936; and his M. D. four years later from Tulane, interning at Charity Hospital, New Orleans. Sandwiched between residency on the Tulane University Surgical Staff, Charity Hospital (July 1941 to January 1942, and 1946-48) was four years in the U. S. Navy, much of it aboard a destroyer in the South Pacific.



Dr. McCafferty, Sr.



Dr. McCafferty, Jr.

Dr. Emit Luther McCafferty, Jr., was married to Corinna Herndon of Mobile Jan. 10, 1945, and there are three children—Emit Luther III, a law senior at the University of Alabama; Corinna, a junior at the University; and Elizabeth, a freshman at Stratford College, Danville, Va.

In addition to his term as president of the Medical Association of the State of Alabama, further evidences of the activity of Dr. "June" McCafferty in the civic and professional life of his community and his state are to be found in the following:

President, Gulf Coast Clinical Society; president, Medical Staff, Mobile Infirmary (1960), Member, Organizing Committee, Allied Arts Association of Mobile (1961) and currently on Board of Trustees and Executive Committee (1969-70), member, Senior Bowl Committee of Mobile Arts and Sports Association, as chairman of Medical Committee continuously since its organization in 1959; Board of Directors, Jaguar Club, University of South Alabama since 1967; president, Touchdown Club, 1966-68; currently on Board of Trustees, MASA; Board of Directors, Mobile Symphony Association (1960-63); Board of Directors, Mobile Chapter, Boys Clubs of America.

Distinguished Anniston Doctor in New Year's 50-Year Club

"Among people I'd like to know" is a thought that will flash through the mind of almost anyone reading a biographical sketch of Gerald Ginness Woodruff, M. D., of Anniston, one of ten Alabama doctors qualifying in 1970 for admission to the Medical Association's 50-Year Club.



DR. WOODRUFF, SR.

In this time, when all the world seems emotionally sick, there is something steadying and reassuring in a simple rundown of high-points in the life story to date of this Calhoun County physician and surgeon who interrupted his medical training to enter World War I, who in 1929 was president of the American Legion, in 1933 was voted the "Model Father of Anniston," who was voted by his Ministerial Association "The Outstanding Christian Doctor of Calhoun County," a life Deacon of Parker Memorial Baptist Church, which on Dec. 3, 1957, observed "Dr. Woodruff Appreciation Day"; a past president of the Anniston Kiwanis Club, presented by the Choccolocco Council of Boy Scouts an award for "Outstanding services rendered boyhood in the work of the Council," a reserve officer recalled to active duty in World War II and assigned to recruiting Alabama doctors for service, accredited with making Alabama the first state in the nation to meet its doctor quota; returning from war duty with the rank of Colonel and wearing the French Croix de Guerre and the Legion of Honor.

In 1926, Dr. Woodruff was married to Miss Flora Campbell of Columbia, Ala. And it is significant that 22 years later Mrs. Woodruff was serving as the 21st President of WAMASA. They have three children: Gerald, Jr., an Anniston pediatrician, who thus qualifies these two Woodruffs for inclusion in another Journal feature: "Fathers and Sons in Medicine"; Jane, whose husband is R. T. Lucas, Jr., M. D., a Charlotte, N. C., pediatrician; and Roy, an ordained Baptist minister with his baccalaureate and doctorate from the Southern Baptist Theological Seminary, Louisville, currently director of Pastoral Care at Bryce Hospital, who has just published his first book, "Alcoholism and Christian Experience."



DR. WOODRUFF, JR.

The Lucases have three children—Cam, Bob and Dan—whose other grandfather also is an M. D., practicing in Shreveport, La. Dr. Roy Woodruff is married to a Pensacola, Fla., girl, the former Kay Jernigan. And they have one son, Charles Roy Woodruff, Jr.

Dr. Gerald Woodruff, Jr., followed in his father's footsteps—to the University of Alabama for his baccalaureate, a member of the ATO fraternity; to Tulane for his degree in Medicine, where he served as vice president of the Phi Chi medical fraternity; serving overseas in the Medical Corps, where he was presented the Commendation Medal for meritorious service in Korea; again like his father, returning to his native Anniston to practice.

Gerald, Jr., is married to the former Harriet Bowen of Charleston, S. C., the daughter of an M. D., and they have five children: Gerald III, Bowen, Rhett, David and Margaret. In 1965 he was listed as one of the outstanding young men of Amercia and, again like his father, is a past president of the Cal-

houn County Medical Society. In 1963 he was general chairman of the Calhoun County Stop-Polio Sunday Campaign, which resulted in the immunization of more than 80 per cent of the county population against polio. He is a member of Grace Episcopal Church where he has served on the vestry and as chairman of the Episcopal Day School Board.

Incidentally, the senior Woodruff is the second prominent Alabamian of that name to wear the soubriquet, "Fuzzy." In the early days of this century a nationally known newspaperman, a native Montgomerian, was "Fuzzy" Woodruff.

Dr. Craddock Dead At 80

French Hood Craddock, M. D., a onetime member of the University of Alabama football team, a past president of the Alabama Alumni Association, a former member of MASA's Board of Censors, and founder of the Medical Department of Avondale Mills, and a vice president of the company, is dead at the age of 80.



Dr. F. H. Craddock

Graduating from the University in 1909, he earned his M. D. degree three years later from Tulane. The French Croix de Guerre was awarded him for his services overseas in World War I. He was a past president of the Sylacauga Chamber of Commerce, chairman of the Sylacauga Library Board, a member of the Sylacauga Board of Education, a charter member of that city's Rotary Club, and a member of the First United Methodist Church.

Surviving is a son, Walker P. Craddock, presently a member of the University of Alabama faculty. Funeral and burial were in Sylacauga.



MEDICAL REGIMENTATION by the government will be challenged at the polls, if plans aiming at putting Doctors in the Legislature and at a closer scrutiny at others in the Legislature, materialize . . . ALAPAC's Board of Directors met last month to review the entire program which has the enthusiastic endorsement both of John M. Chenault, M. D., chairman of MASA's Board of Censors, and C. Kermit Pitt, M. D., president of the Medical Association . . . Among those attending the meeting were: Mrs. Benjamin H. Johnson, Jr., Bessemer, president of WAMASA (in oval); from left, top: Grover C. Murchison, Jr., M. D., Montgomery, ALAPAC Board chairman; Carl A. Grote, Jr., M. D., Huntsville, 8th district; John C. Sullivan, M. D., Montgomery, ALAPAC secretary-treasurer; from left below: Robert J. McLaughlin, M. D., Ozark, 3rd district; John H. Nelson, M. D., Tuscaloosa, 5th; Richard F. Bliss, M. D., Talladega, 4th.

Inner Sites...

In Cystitis...Azo Gantanol® focuses analgesic-antibacterial activity where it counts



The mucosa: specific analgesia usually within 30 minutes

Azo (phenazopyridine HCl) effects specific mucosal analgesia, relieving the dysuria, discomfort and burning which are virtually always a part of acute urinary tract infections.

Interstitial fluids: ready diffusion of antibacterial

Gantanol (sulfamethoxazole) is readily diffused into interstitial fluids to provide efficient antibacterial activity at foci of infection. This distribution, plus continuous antibacterial levels in blood and urine, has afforded effectiveness in the majority of infections in which it has been used.

Blood and urine: therapeutic antibacterial levels within 2 hours for up to 12 hours

Gantanol (sulfamethoxazole) produces prompt and prolonged therapeutic levels, in both blood and urine, with convenient *b.i.d.* dosage. Clinical response is usually obtained within 24 to 48 hours. The wide antibacterial spectrum of Gantanol includes *E. coli* and a variety of other susceptible gram-negative and gram-positive pathogens in urinary tract infections.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Urinary tract infections with associated pain or discomfort when due to susceptible organisms; prophylactically in urologic surgery, catheterization and instrumentation.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

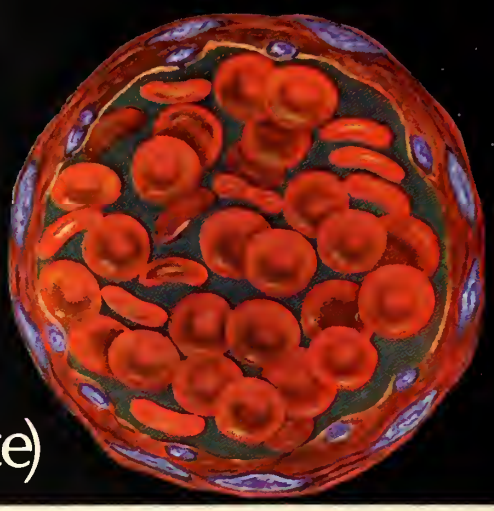
Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

ROCHE
Roche LABORATORIES
Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Azo Gantanol®

(Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.)

Roniacol® Timespan®
(nicotinyl alcohol tartrate)



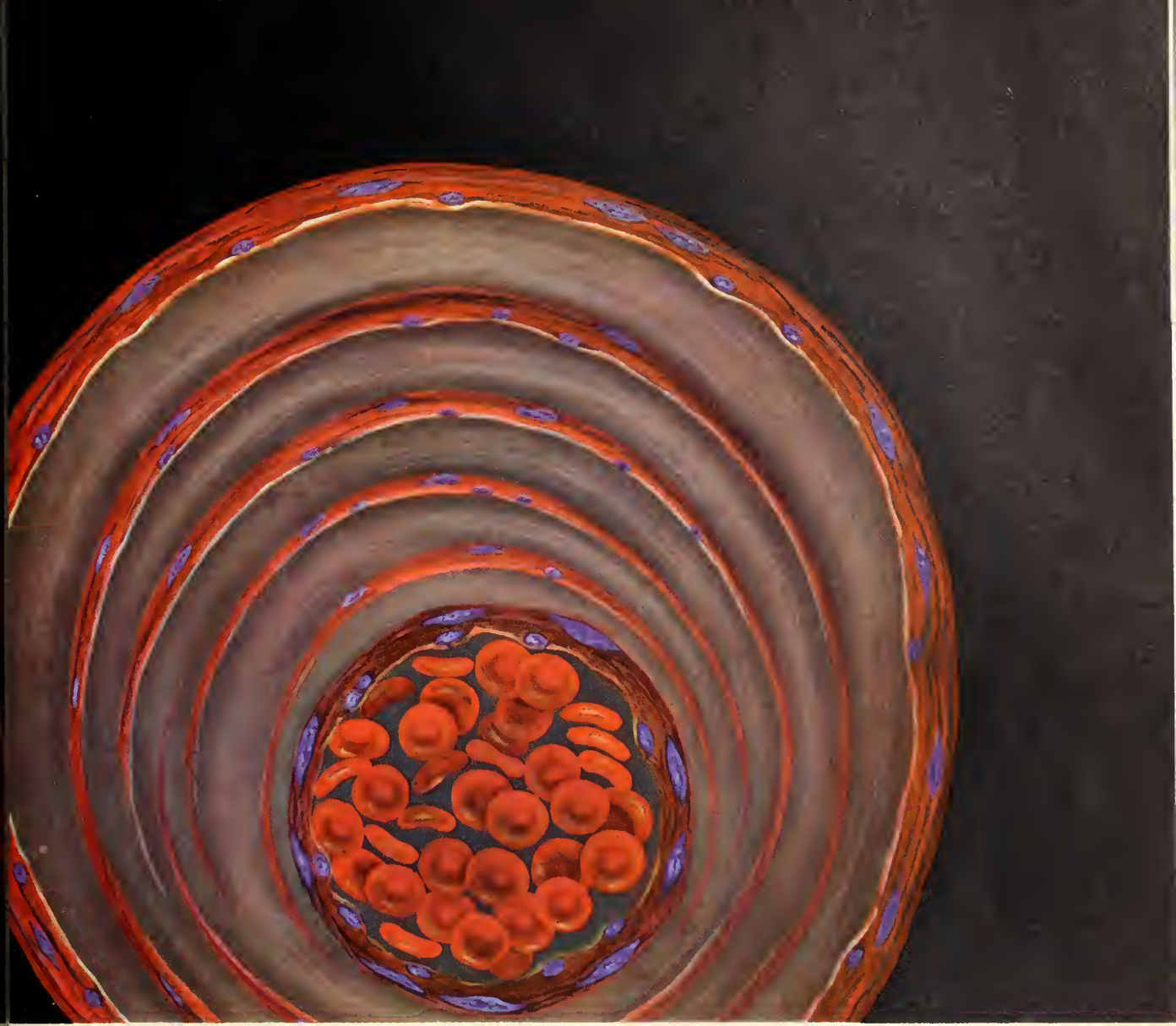
Because peripheral vasodilatio is needed now... and must often be continued

Roniacol Timespan (nicotinyl alcohol tartrate) can make a significant contribution to effective treatment of peripheral vascular disorders. It is directed specifically toward improvement of peripheral blood flow, relief of ischemic symptoms, and the long-term management of these conditions.

Specific pharmacologic action—Roniacol (nicotinyl alcohol) acts selectively by relaxing smooth muscle of peripheral blood vessels. Onset of action is smooth and gradual, rarely causing severe flushing.

Relative freedom from side effects—Side effects that may occur occasionally with Roniacol seldom require discontinuation of therapy

Prolonged, continuous drug release—Prolonged peripheral vasodilation is provided sustained-release Roniacol Timespan (nicc alcohol tartrate) Tablets. Part of the drug b comes available immediately, the remainc continuously over a period of up to 12 hou and dilation of constricted peripheral vess usually maintained. Thus, with a single dos medication, patients can enjoy the benefit increased peripheral blood flow in ischem extremities for up to 12 hours.



nooth peripheral vasodilation from initial osage...extended with nple, well-tolerated, b.i.d. dosage

prolonged action of Roniacol Timespan otinyl alcohol tartrate) together with its r benefits offer a therapeutically practical sure in the long-term management of pheral vascular disease–advantages cially important for older patients.

re prescribing, please consult complete uct information, a summary of which ws:

ations: Conditions associated with ient circulation; e.g., peripheral vascular se, vascular spasm, varicose ulcers, bital ulcers, chilblains, Meniere's syn- e and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50 and 500.

ROCHE

Roche
LABORATORIES
Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Art is a conception of peripheral vasodilation.

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieve by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

Hobbies To Fill A Doctor's Leisure

When The Billfish Leaps From A Hundred Fathoms Deep

A billfish is called a billfish because it has a bill. Elementary, my dear Watson!

There are two kinds of doctors—those with hobbies and those without. There are two kinds of hobbies—dynamic and sedentary.



DR. ST. AMANT

With deep-sea angling among the former, there are two kinds of billfish—freshwater and saltwater.

The freshwater variety, the gar, is known to anglers generally for its nuisance value. One who has for a hobby studies of the universe's past knows he will find in the gar's obvious Ordovician ancestry reason enough for calling it "a living fossil."

The saltwater species of billfish, usually represented by the formidable sailfish, is a favored hobby pursued by a group of South Alabama doctors and their families. And these doctors have two ways of handling their catches—either keeping them (for pictures, for the taxidermist's skill, or because the catch is mortally hurt) or tagging them and releasing them (so we may have a little better knowledge of their migratory habits and the distances they travel).

To point the finger at any billfishing enthusiast on the Gulf coast and say "Here is the leader of this exciting hobby" is to invite criticism and ridicule. But a non-doctor, a kinsman of the author of this article, a friend and fellow-enthusiast of Chester Phillips St. Amant (pronounced as though it were spelled Santamont), Jr., M. D., member of the Escambia County Medical Society and chairman of its Board of Censors, first mentioned this Atmore doctor in connection with the hobby.

Dr. St. Amant promptly introduced three other South Alabama doctors in connection with the sport—Marshall Eskridge, M. D., a radiologist; Robert Hiden Mudd, M. D., a neurosurgeon; and Claude Morris Warren, Jr., M. D., an OALA-R, all of Mobile. As this is generally a family hobby, and as one accompanying picture shows, still another M. D.



A SPECTACULAR BILLFISH catch by anybody's yardstick, with the catcher, Dr. C. P. St. Amant posed alongside.



THE WARRENS display a modest catch! From left: Carolyn (Eskridge) Warren, Dr. Claude Warren, Jr., Dr. Claude Warren III, and Joseph P. Warren. A more complete family picture would have included all the Eskridges and the Lingos; Dr. Marshall Eskridge is the father of Mrs. Claude Warren III, and Dr. John Lingo the father of Mrs. Joseph P. Warren.

enthusiast is Dr. Claude Morris Warren III.

In order of their appearance:

Born in Baton Rouge, Dr. St. Amant is married to the former Gene McDuffie, New Orleans. They have one child, Elaine, and one grandchild, George Laurie, Jr., with, the Atmore doctor adds confidently, "a granddaughter due on my birthday," three days after Christmas.

Dr. St. Amant received both his baccalaureate and his M. D. from L. S. U. Between then and his developing passion for billfishing aboard his 34-foot boat, *Ragin Cajun I,* came internship in City Hospital (now Mobile General), a tour of USNR duty, two years of general practice in Grove Hill, and from 1948 forward in Atmore.

Three seasons of fishing aboard his first boat and his present one, *Ragin Cajun II,* a 38-footer powered with twin diesels, catches have totaled 25 billfish, including 2 blue marlin. Fifteen of these have been mounted (by very happy fishermen!), five have been tagged and released, and the remaining five brought aboard because they were dead or severely injured.

Mrs. St. Amant is about as enthusiastic and as skilled as her husband. She has caught her share of sailfish and white marlin and has one 190-pound blue marlin to her credit. But generally she operates the boat while the lines are out, her husband staying in the cockpit.

* * *

Marshall Eskridge, M. D., senior of this group of sailfish enthusiasts, is a native of Gastonburg, his mother of the politically well known Goode family of Wilcox County. His baccalaureate is from the University of



TRIO OF MIGHTY SAILFISH, displayed by (from left): Dr. Marshall Eskridge, Jerry Pilgrim, Joe and John Eskridge.

Alabama, and his M. D. from Tulane. Between then and his opening practice as a radiologist in Mobile Infirmary in 1948, came internship at Lloyd Noland, Fairfield, and service in the Navy, including specialty training at the U. S. Naval Hospital, Bethesda, Md., and Johns Hopkins, Baltimore.

Dr. Eskridge is married to the former Margaret Blombergson, and they have two sons, three daughters, and two grandchildren.

For many years Dr. Eskridge fished the Alabama Deep Sea Rodeo with the late Dr.

(Continued on Page 606)



Ornade® Spansule®

brand of
sustained release capsules

Trademark

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

Prompt relief from nasal congestion and hypersecretion due to colds.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage In Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.
Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.
Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

SK&F Smith Kline & French Laboratories



SECOND PLACE AWARD-WINNER is this 202-pound blue marlin, landed for the Pensacola Open Billfish Tournament last year by Dr. Robert H. Mudd, Mobile. To the right is a friend and fishing companion, Jere Austill, Jr., Mobile attorney.

Victor Hudson aboard the latter's boat, "Em Dee." Dr. Hudson knew about the billfish in 100-fathom water off our Gulf coast. In 1958 they went out about 75 miles during the rodeo, looking for them, "got caught in a storm, got lost, and made our way back to Dauphin Island in time to see the end of that year's rodeo."

In 1963, Dr. Eskridge continued, "as my sons got old enough, we bought a 21-foot inboard-outboard, fished with it a couple of seasons, then got a 30-foot twin engine cabin cruiser. In the spring of 1967 we bought a 40-foot sportsfisherman. These boats were all named 'Snoopy' by the boys for a special heroic black and white thomas cat by that name they had loved some years before.

"We began fishing for billfish in the summer of 1966, when very few private boats went to the 100-fathom water . . . But my greatest thrill was when my wife brought in a record 112-pound white marlin with my youngest son (then age 12) and I the only others aboard . . .

"This past summer the billfish were late coming in and the weekend weather was often too rough to go out. Then the hurricane Camille finished my season. However, we caught two billfish. One was kept for mounting, the other tagged and released."

Then Dr. Eskridge goes on to reassure those who might be hesitant about following his boat wake into 100-fathom water: "This type of offshore fishing is safe if one checks the weather forecast, has a good reliable boat, sufficient electronic gear including two-way radio, and a skipper thoroughly grounded in seamanship and offshore navigation . . . I've found fishing and hunting my best way of bridging the generation gap between me and my sons and their buddies. It works."

* * *

At this point, the story of billfishing off our Gulf coast becomes really a family affair. For Dr. Eskridge's daughter Carolyn is the daughter-in-law of the third M. D. mentioned earlier, Dr. Claude Morris Warren, Jr., and the wife of Dr. Claude M. Warren III. The Drs. Warren were subjects of a Journal per-



ABOARD THE SNOOPY: John F. Allen beside a hefty 277-pound blue marlin he brought to gaff; Margaret (Mrs. Marshall) Eskridge with her 112-pound white marlin, which took first prize in the Mobile Big Game Fishing Club contest in September, 1966; and Dr. Eskridge with a large wahoo.

(Continued on Following Page)

BUREAU OF VITAL STATISTICS

PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA

Ralph W. Roberts, M. S., Director

AUGUST 1969

Live Births / Deaths / Causes of Death	Number Recorded During 1969			Rates* (Annual Basis)		
	Total	White	Non-White	1969	1968	1967
Live Births	6,174	4,148	2,026	19.9	18.6	18.7
Deaths	2,619	1,842	777	8.5	8.2	8.0
Fetal Deaths	89	44	45	14.2	20.4	18.7
Infant Deaths—						
under one month	99	52	47	16.0	18.9	16.4
under one year	134	70	64	21.7	24.2	21.4
Maternal Deaths	2	1	1	3.2	1.7	6.9
Causes of Death						
Bacillary dysentery, amebiasis, 004, 006						
Enteritis, other diarrheal diseases, 008, 009	8	2	*	2.6	†	†
Tuberculosis, all forms, 010-019	13	9	4	4.2	4.9	7.3
Diphtheria, 032						
Whooping Cough, 033					0.3	
Meningococcal infections, 036						
Poliomyelitis (acute), 040-043**					0.3	
Measles, 055						0.3
Syphilis, 090-097	2	2		0.6	1.3	0.3
Malignant Neoplasms, 140-209	390	304	86	126.0	114.3	125.9
Diabetes Mellitus, 250	48	27	21	15.5	13.4	13.5
Major cardiovascular diseases, 390-448	1,273	922	351	411.2	†	†
Diseases of heart, 390-398, 402, 404, 410-429	839	649	190	271.0	265.3	257.1
Rheumatic fever & heart, 390-398	8	5	3	2.6	†	†
Hypertensive heart & renal diseases, 402, 404	35	19	16	11.3	†	†
Ischemic heart disease, 410-414	709	561	148	229.0	†	†
Cerebrovascular disease, 430-438	348	230	118	112.4	109.1	105.8
Diseases of the arteries, 440-448	75	41	34	24.2	21.3	23.8
Influenza, 470-474						0.3
Pneumonia, 480-486	43	28	15	13.9	18.0	16.9
Bronchitis, emphysema, asthma, 490-493	24	23	1	7.8	†	†
Appendicitis, 540-543	2	1	1	0.6	0.7	1.0
Hernia, intestinal obstr., 550-553, 560	11	8	3	3.6	3.3	1.0
Cirrhosis of liver, 571	14	10	4	4.5	6.9	5.9
Complications of preg., childbirth, 630-678	2	1	1	3.2	1.7	6.9
Congenital anomalies, 740-759	25	22	3	4.0	3.7	4.4
Immaturity, 777	19	12	7	3.1	5.8	4.8
Accidents, total, 800-949	217	154	63	70.1	64.9	67.7
Motor vehicle accidents, 810-823, 940	141	101	40	45.5	31.1	40.6
All other defined causes	366	243	123	118.2	123.5	110.7
Symptoms & ill-defined, 780-796	162	74	88	52.3	46.5	43.3

manent feature, Fathers and Sons in Medicine, several months ago.

But this is by no means the conclusion of the roll call of sailfishing enthusiasts in the Warren family. The elder Dr. Warren's younger son, Joseph P. Warren, is married to a devotee of this famous water sport, the former Susan Lingo, daughter of Dr. John Kellam Lingo, OALR, also of Mobile. And Dr. Lingo, Dr. Warren adds in comment on this interesting family, "does more billfishing than anyone."

Mrs. Susan (Lingo) Warren "boated one large white marlin and several large dolphin this past season."

* * *

Robert Hiden Mudd, M. D., Mobile neurosurgeon, the fourth doctor mentioned in the beginning of this article on billfish, has a distinction almost unique in the sport. A couple of years ago, with only his wife and 12-year-old son aboard, he managed to deck a huge 300-pound blue marlin, which today is a prized wall decoration in his trophy room.

Born in Birmingham on Feb. 12, a few years back, Dr. Mudd attended the public schools of the Magic City and earned his baccalaureate at the University of Alabama before going through the University of Pennsylvania for his M. D. He is married to a Birmingham girl, the former Emelil Davis, and they have two children, Robert, Jr., now 14, and Margo, 11.

But a more detailed story of Dr. Mudd will appear next month in connection with another feature starting at that time in the Journal. He is one of 23 members of the Flying Physicians Association, using his own Cessna Skylane 182 to fly to his favorite fishing grounds.

---

*Rates: Births and deaths—per 1,000 populaton
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

**Does not include late effects

†NOTE: The Eighth Revision of ICD (New Revised Code) is used beginning with January 1969. Comparison with statistics compiled under the former Code (Seventh Revision ICD) and rates cannot be made. Direct to the Alabama Bureau of Vital Statistics any question about comparability of statistics compiled and rates under the new vs. the former ICD.

PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. MASA members having knowledge of practice opportunities or wishing to relocate their own practices are urged to communicate with the Placement Service. For further information: write Mr. Emmett Wyatt, Executive Assistant, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama 36104, or Telephone 263-6441.

Locations Wanted

General Practice—

Age 33, Medical College of Georgia 1968, seeking parttime employment on weekends and holidays relieving a general practitioner or emergency room duties in south Alabama within reasonable commuting distance of Pensacola, Fla. LW-1

Age 38; University of Oklahoma, 1955; seeking associate, institutional or industrial practice; in town of 10,000 plus population; interest in surgery. LW-5

Age 28; University of Tennessee, 1965. LW-7

Age 27, Medical College of South Carolina, 1966; seeking location in Gadsden area or in southern part of state in town of 5-7,000 population; available July 1, 1971. LW-7/1

Age 60, University of Arkansas 1932, seeking location for general or industrial practice. Available May 1969. LW-7/3

Age 34; University of Tennessee 1964; seeking associate practice. LW-7/5

Internal Medicine—

Age 59, Cornell University 1933, American Board certified, seeking group practice. LW-8

Age 31, Medical College of South Carolina 1964, Available July 1970. LW-9

Age 37, Duke University, 1956; Board certified, seeking group, associate, or institutional practice. LW-13

Age 33; University of Miami 1962; Board eligible; National Board; seeking solo, group practice, hospital practice, or industrial practice. Available July 1969. LW-13/1

Age 31; Medical College of Georgia 1963; seeking location for practice of internal medicine-cardiology. Available 1970. LW-13/2

Neurology—

Age 32, Medical College of Georgia, 1964, seeking assistant or associate, or institutional practice. LW-14

Age 31; Harvard 1962; Board eligible; National Board; seeking solo, group or associate practice. Available July 1969. LW-15

Age 29, Indiana Univ., 1964; Board eligible; seeking assistant or associate practice in city of over 100,000 population; available July 1, 1969. LW-17/1

Obstetrics-Gynecology—

Age 49, University of Nebraska, 1943; Board certified, seeking group or institutional practice. LW-19

Age 34, Medical College of Virginia, 1961, Board eligible, seeking group or associate practice. LW-20

Age 33; University of Illinois, 1964; seeking associate practice. LW-21

Ophthalmology—

Age 33; St. Louis University, 1962; seeking solo, or associate practice; available July 1, 1969. LW-21/1

Otolaryngology—

Age 32, University of Pennsylvania 1962, seeking associate practice. Available April 1970. LW-21/2

Pathology

Age 32, University of Louisville 1966, seeking associate or institutional practice. Available July 1970. LW-21/4

Age 52; New York State University 1940; American Board certified; National Board; seeking institutional practice. Available immediately. LW-21/5

Radiology

Age 28; Northwestern University 1964; completing radiology residency. Available July 1971. LW-24

Age 43; Louisiana State University 1953; Board certified, seeking associate practice, preferably in southern section of state. Available January 1970. LW-24/1

Surgery—

Age 33; University of Missouri, 1961; seeking group or associate practice. Available January 1969. LW-27

Age 38; Emory University, 1956; Board eligible, seeking group, associate, or institutional practice. LW-28

Age 36, Indiana University 1961; Board eligible; seeking practice in city of 100,000 plus population. Available July 1969. LW-31/1

Age 37, University of Paris 1961; seeking group or institutional practice in city of 80,000 plus population. Available July 1969. LW-31/2

Age 48; Marquette University 1943; Board eligible; seeking institutional practice in east Alabama. Available July 1969. LW-31/3

Age 31; St. Louis University 1963, American Board certified; seeking associate practice. LW-31/3

Age 48; University of Pennsylvania 1950; Board eligible; seeking solo or group practice. LW-31/4

Age 31; Medical College of Alabama 1963; American Board certified; seeking associate practice. Available July 1970. LW-31/4

(Continued on Page 609)

Locations Wanted

(Continued from Page 608)

Age 36, Emory University 1959, Board certified, seeking associate practice. Available September 1970. LW-31/5

Urology—

Age 30; Louisiana State University, 1963; Board eligible, seeking associate, or group practice. LW-32

Age 31, Chicago Medical School 1963, seeking associate practice in Montgomery. Available July 1970. LW-32/1

Age 32, Albany Medical College 1962, Board eligible, seeking associate practice. Available July 1970. LW-32/2

Student Health—

Age 40, University of Oklahoma 1955, seeking institutional practice. LW-33

Physicians Wanted

Special Openings—

General surgeon, Board certified, needs young associate to do general practice including obstetrics. Salary negotiable. PW-19

Specialist in the following fields: Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practitioners. 58-bed fully accredited general hospital with 91-bed addition recently completed. Modern new office space available. PW-20

Pediatrician, Internist, and ENT specialist to join a well-established group practice in a community of 40,000 in East Alabama. The community has a 125-bed accredited hospital, 32-bed extended care facility. Good transportation on interstate with quick access to metropolitan area. Will pay travel expense for interview. PW-20-1

Opportunity for ENT, Internal Medicine, and Orthopedic Surgery practitioners to join partnership at clinic located in city of 38,000 population in trade area of 150,000 population in northeast Alabama. PW-20/2

Position for full-time industrial practice at textile plant with 2,400 employees at Decatur, Alabama. PW-20/3

Internists, Board-certified or eligible. One needed now and another in 1 or 2 years. For early partnership with internist in south Alabama city of 40,000 plus population. New office building adjacent to 181-bed hospital. Practice largely hospital in-patient and Cardiology. PW-21

Opportunity for a Board certified or eligible surgeon to be associated with a Board surgeon in city of 150,000 population. PW-21/1

The Alabama Department of Mental Health is seeking several physicians. Vacancies exist at Bryce Hospital, Tuscaloosa, and Searcy Hospital, Mt. Vernon. PW-22

General Practitioner or Internist for associate or separate practice in Birmingham. Modern office space and excellent hospital facilities. PW-26

Obstetrician-Gynecologist—

Excellent opportunity for a trained Ob-Gyn man, who would join a two-man partnership in city of 30,000 population located in south central Alabama. Salary is proposed for the first year, with partnership thereafter. PW-25

General Practitioners—

For town of 2,000 population located in trade area of 15,000 population in northeast Alabama. Nearest metropolitan centers 30 miles distance. Industrial area. Clinic and some office equipment available. Several churches, schools, and civic clubs. PW-23

Opportunity for GP to join well established four-man partnership; three general practitioners and one board certified surgeon. Practice located in city of 8,000 population, trade area of 60,000, north-central Alabama. Modern new partnership-owned offices adjacent to modern 125-bed fully accredited hospital. Salaried first year with possible partnership status at end of first year. PW-27

Opportunity in town of 4,000 population in trade area of 50,000 population, located within 100 miles of two metropolitan areas in south Alabama. Industrial and farming area. 44-bed hospital. Office space and equipment available in new building with another physician. Several churches, schools, and service clubs. PW-1

For community of 1,500 population located in south Alabama near city of 12,000 population. Hospitals located within 25 miles. Office space and equipment available. Farming, cattle and textile industries in the area. Several churches and school. Civic clubs and golf courses. PW-1-1

For town of 10,000 population in county of 40,000 population located in scenic mountainous section of Northeast Alabama. Office space and equipment available. Hill-Burton hospital-nursing home. Expanding industries in top agricultural area. PW-1-2

For community of 2,000 population, plus large trade area, located in Southeast Alabama. Modern clinic, fully equipped. PW-1-3

Opportunity in port town of 1,000 plus population in population center of 10,000 located in Southeast Alabama. Clinic available. Hospital located less than 20 miles away. Recreational advantages for water sports. Expanding industrial and farming area. Churches and schools. PW-1-4

For town of approximately 1,000 population in Northwest Alabama, near Tennessee Valley waterways. New 15-bed clinic available. Centrally located near metropolitan areas. Extensive industrial developments. PW-1-5

(Continued on Page 610)

Physicians Wanted

(Continued from Page 609)

For town of 12,500 population in trade area of 50,000 located in South Alabama. Nearest large city with population of 145,000 is 80 miles away. Two hospitals with 140 beds. Numerous small industries. Several churches and schools. Recreational activities include water sports and golf course. PW-1-6

General Practitioner to join partnership in town of 3,000 population, plus trade area of 20,000 population in northwest Alabama. Modern office building with six examining rooms. Full partnership at beginning of third year. New 30-bed Hill-Burton hospital. Salary open. PW-1/7

Opportunity in community of 3,000 population with over 8,000 population in trade area, near metropolitan area in northwest Alabama. Clinic and office equipment available. New 400-bed hospital and older hospital, and several nursing homes. PW-1/8

For town of 2,000 population in trade area of 7,000 population located in west Alabama. Physician recently died. Nearest city is 30 miles away. Medical facilities include Hill-Burton hospital and nursing home. Churches, schools, civic clubs, and recreational advantages. PW-1/9

For town of 1,800 population located in southeast Alabama in a population center of 10,000 population. PW-1/10

For town of 7,000 population located in population center of 15,000 population located in northeast Alabama. Office space and equipment available. Hospitals located in adjoining towns within 12 miles. State University located in the town. PW-1/11

For town of 2,500 population located in northeast Alabama. 17-room modern brick clinic fully equipped. Hospital nearby. Excellent schools and recreational advantages, water sports. PW-1/12

For town of 5,000 population, located in northwest Alabama. 55-bed hospital being completely renovated, and an adjoining 69-bed nursing home. PW-1/13

Opportunity in well situated central Alabama county, trade area of 18,000 population, manufacturing, mining, farming region. New office building furnished. 33-bed accredited hospital. Excellent recreational facilities including new country club. PW-1/14

Opportunity for group practice in town of 10,000 population in north Alabama. PW-2

Physician wanted to join 39 year old Medical College of Alabama graduate in a well established general practice in West Central Alabama town. Salary initially followed soon by full partnership. PW-3

Physician wanted to join well established partnership in Northwest Alabama city of 15,000 population. Two accredited hospitals, junior college, schools, churches, recreational activities. No obstetrics or surgery. New office building. PW-7

For city of approximately 15,000 population in north Alabama, with trade area of approximately 45,000 population. Hospital with over 100 beds, and expansion planned for next year. Nursing homes in the area. Industrial growth and agricultural region. Several churches and schools. Golf course, civic and fraternal organizations. PW-8

For city of 5,000 population located 80 miles northwest of Birmingham. Industrial area. JCAH certified hospital facilities of 70 beds. Office space available for $200 per month. Guaranteed income. One physician in city desires partner, no investment, or associate. PW-1/15

For community of 2,000 population located in central Alabama, 30 miles southeast of Birmingham. Farming area. Clinic available. PW-1/16

For town of 3,600 population in trade area of 5,000-7,000 within 100 miles of two large cities and the Gulf Coast. 50-bed hospital located in the town. Office space available. Agricultural and expanding industrial area. Several churches and two schools. Recreational activities in the town as well as nearby—golf course, hunting and fishing. PW-17

Unusual opportunity for two general practitioners with military obligations satisfied at a modern fifty bed facility located 15 minutes drive from largest metropolitan center in north-central Alabama. Construction of a new two-story office building is scheduled to begin soon. PW-18

Opportunity in city of 5,000 population located in Northeast Alabama in trade area of approximately 10,000 population. Office space available. One physician died recently. Hospital and nursing home in the city. PW-19

Hospital based professional association in suburb of Birmingham is seeking a young general practitioner who has completed military obligation. High income, profit sharing, paid vacation and retirement plan. Complete facilities available. No investment required. PW-19/1

"anorectal disorders"



This Rectopath Model
may help you explain
certain anorectal disorders
to some of your patients.
It is yours on request.

See next page for details.

"anorectal disorder"

includes a range of problems. For symptomatic relief in some of these disorders consider a member of the Anusol Family...

One suppository morning and evening and after each bowel movement.

ANUSOL®

soothing, palliative relief of minor pain, itching, burning, and other associated discomforts.

Each ANUSOL suppository contains bismuth subgallate (2.25%), bismuth resorcin compound (1.75%), benzyl benzoate (1.2%), Peruvian balsam (1.8%), zinc oxide (11.0%), and boric acid (5.0%), plus the following inactive ingredients: bismuth subiodide, calcium phosphate, hydrogenated vegetable oil, and coloring in a cacao butter and white wax base.

One suppository morning and evening for 3 to 5 days.

ANUSOL-HC®

prompt reduction of inflammation plus the soothing effects of regular Anusol.

Each ANUSOL-HC suppository contains, in addition to the regular Anusol formula, 10 mg. hydrocortisone acetate.

Precautions: Prolonged use of Anusol-HC might produce systemic corticosteroid effects.

One suppository every 3 to 4 hours, or every 2 hours if symptoms are severe.

ANUGESIC®

when severe pain requires prompt relief, pramoxine HCl plus the soothing Anusol formula.

Each ANUGESIC suppository contains: 61 mg. bismuth subgallate, 47 mg. bismuth resorcin compound, 32.4 mg. benzyl benzoate, 48.6 mg. Peruvian balsam, 300 mg. zinc oxide, 135 mg. boric acid, and 25 mg. pramoxine hydrochloride. Also contains the following inactive ingredients: bismuth subiodide, calcium phosphate, white wax, benzoinated lard, hydrogenated vegetable oil, and certified coloring in a cacao butter base.

Precautions: If idiosyncratic reaction occurs, discontinue medication.
Symptomatic treatment should not be allowed to delay definitive diagnosis and therapy.

Also available: ANUSOL® OINTMENT AND ANUGESIC® OINTMENT

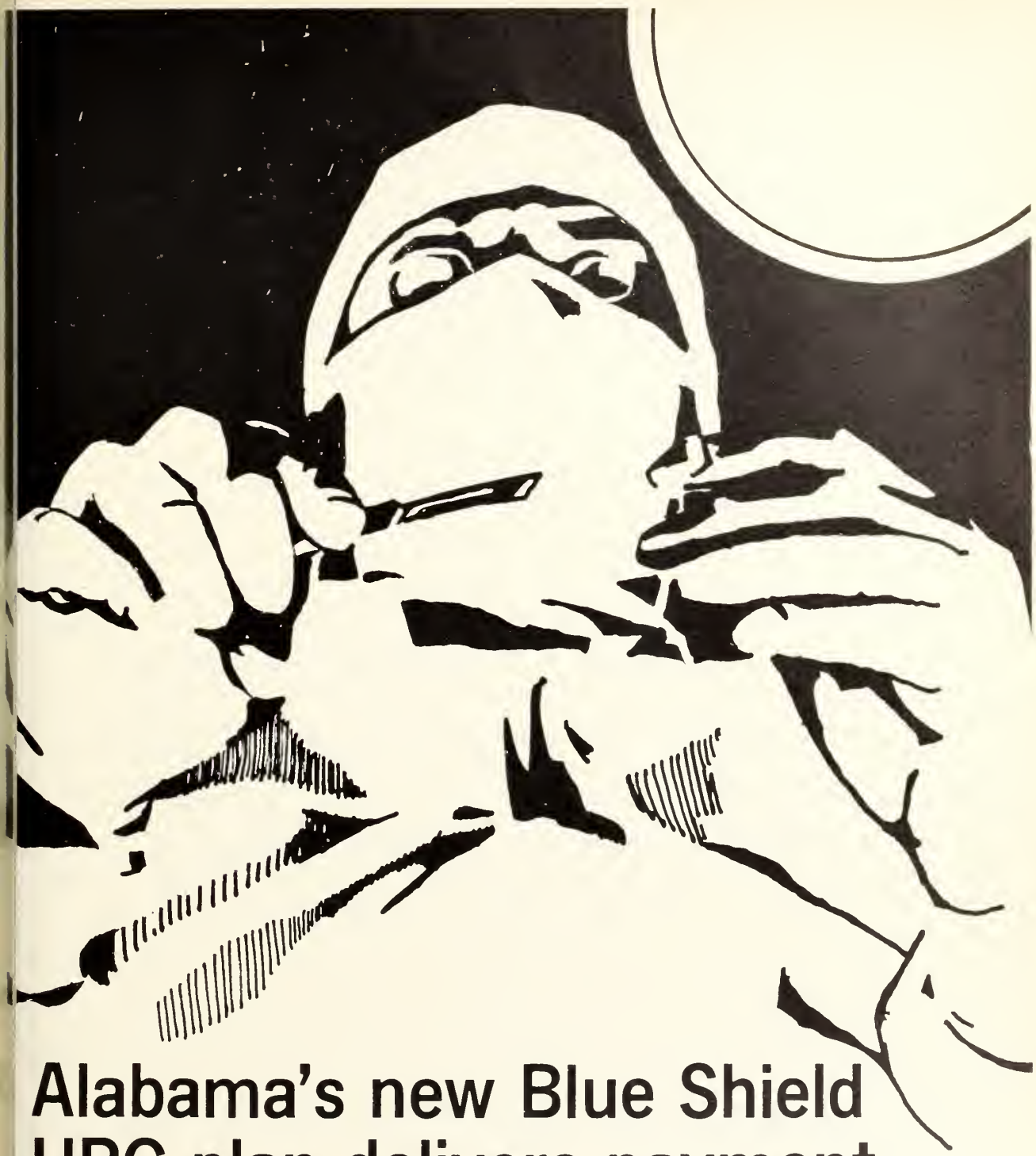


The Rectopath Model is available from your Warner-Chilcott representative or upon request from Warner-Chilcott Labs., Morris Plains, New Jersey 07950.

C

Warner-Chilcott Laboratories, Morris Plains, N. J.

N-91-4C



Alabama's new Blue Shield URC plan delivers payment of physicians' fees under controls derived from the medical profession itself.

BLUE CROSS-BLUE SHIELD OF ALABAMA

®

INDEX TO ADVERTISERS

Arch Laboratories 549

Blue Cross-Blue Shield 613
The Bradley Center ..... 3rd Cover
Burroughs Wellcome 602

Campbell Soup Company 563

Geigy Pharmaceuticals 581, 582, 583
Glenbrook Laboratories 587
Guest House Motel 574

Highland Hospital 614
Hynson, Westcott and Dunning 523

Lederle Laboratories 525, 528, 544, 545, 593
Eli Lilly Company ..... 1st Cover, 550

Parke Davis & Company 543, 566
Pfizer Laboratories 590, 591
Wm. P. Poythress 578

Riker Laboratories 530, 531, 570, 571
A. H. Robins Company 533, 534, 535, 569
Roche Laboratories ..... 588, 589, 599, 600, 601, 4th Cover

Sandoz 546
G. D. Searle Company 564, 565
Smith, Kline & French 531, 605
Strasenburgh Laboratories 575
The Stuart Company ..... 2nd Cover

Warner Chilcott 611, 612
Wyeth Laboratories 540, 541, 576, 577

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: MRS. ELIZABETH HARKINS, ACSW, *Coordinator of Admissions* or

CHARLES W. NEVILLE, JR., M. D., *Assistant Professor of Psychiatry and Medical Director*

Area Code 704 - 254-3201



The Bradley Center --- for the problems of living

An all new homelike open psychiatric residence on a lovely five-acre tract, centrally located within the community, providing a comprehensive range of continuous services, including in-patient, day care, and outpatient treatment. Each patient participates in an extensive and intensive treatment program, based almost exclusively upon multiple psychotherapeutic encounters. These include individual psychotherapy, group psychotherapy, the nursing milieu, occupational therapy, recreational therapy, topical small group discussions, and other group activities in the Center, as well as in the community, depending on individual needs and interests. Medications are prescribed when appropriate.

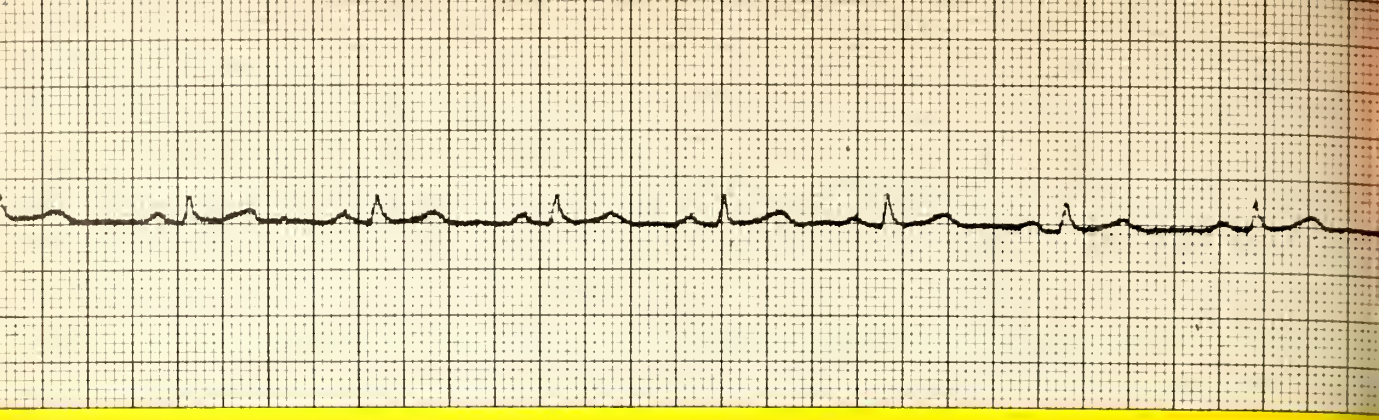
Any individual may be admitted who, in the opinion of the medical staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible family member.

Accredited by the Joint Commission on Accreditation of Hospitals.

Leonard T. Maholick, M. D.
Medical Director

Maj. Gen. (ret.) Howard Snyder
Administrator

THE BRADLEY CENTER, INC.
2000 Sixteenth Avenue
Columbus, Georgia 31901
Area Code 404 324-4882



When disease is ruled out and psychic tension is implicated

Valium® (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

JOURNAL of the Medical Association of the State of ALABAMA

THE COUNTWAY
LIBRARY OF MEDICINE
BOSTON
2 FEB 1970

IN THIS ISSUE

And Next Year is Nineteen Seventy-One . . . 632

Immunologic Psychology and Psychiatry . . . 649

Pulmonary Function Testing for the General Hospital and Physician (Part II) 658



Francis A. Countway Lib. of Medicine
10 Shattuck St.
Boston, Massachusetts 02115

JANUARY 1970

The girth control pill



Tepanil® Ten-tab®
(continuous release form)

(diethylpropion hydrochloride)

works on the appetite not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptic, an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

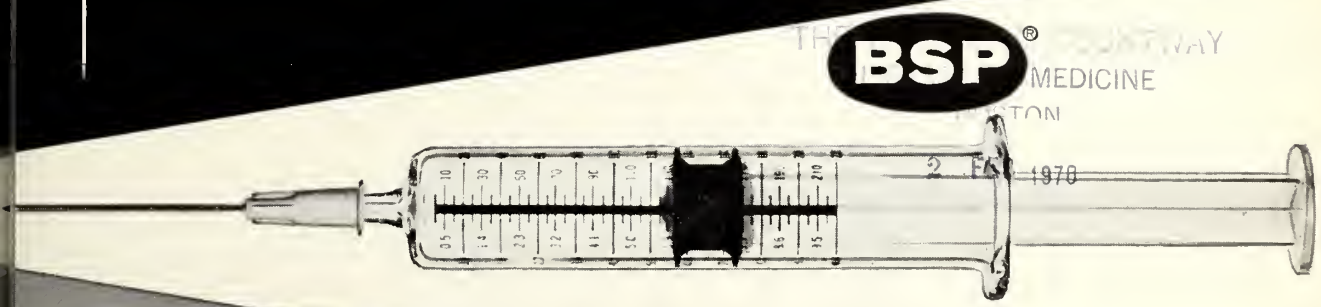
T-006A / 1/70 / U.S. PATENT NO. 3,001,91

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 1914

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)



BROMSULPHALEIN® IN A STERILE, DISPOSABLE, ECONOMICAL UNIT

The Bromsulphalein test is a convenient, sensitive, reliable test of liver function.

The precalibrated syringe contained in the BSP Disposable Unit makes weight calculations unnecessary, providing proper dosage regardless of patient-weight. Each unit contains complete directions for use, precautions and contraindications.

The all-inclusive BSP Disposable Unit provides economic unit dispensing.

Complete literature available on request.

HYNSON, WESTCOTT & DUNNING, INC.

Baltimore, Maryland 21201

(BSP04)

THE JOURNAL

of the

Medical Association of the State of Alabama

Volume 39 • January, 1970 • No. 7

Office of Publication
19 So. Jackson St. Montgomery, Ala. 36104
Subscription Price $5.00 Per Year
$1.00 Per Copy

Second Class Postage Paid at Montgomery, Alabama. Published monthly in Montgomery at 19 South Jackson Street.

Editor-in-Chief
William L. Smith, M. D. Montgomery

Managing Editor
L. P. Patterson Montgomery

Assistant Managing Editor
Mary Nell Williford Montgomery

Associate Editors
J. P. Collier, M. D. Tuscaloosa
John M. Chenault, M. D. Decatur
M. Vaun Adams, M. D. Mobile

Officers of the Association

President
C. Kermit Pitt, M. D. Decatur

President-Elect
S. Buford Word, M. D. Birmingham

Vice-Presidents
F. M. Phillippi, Jr., M. D. Brewton
J. E. Cameron, M. D. Alexander City
O. Emfinger, M. D. Union Springs
Wood S. Herren, M. D. Birmingham

Secretary-Treasurer
William L. Smith, M. D. Montgomery

Executive Director
L. P. Patterson Montgomery

The State Board of Censors
John M. Chenault, M. D., Chmn. Decatur
J. P. Collier, M. D. Tuscaloosa
Hugh E. Gray, M. D. Anniston
Paul W. Burleson, M. D. Birmingham
L. L. Hill, M. D. Montgomery
M. Vaun Adams, M. D. Mobile
J. D. Bush, M. D. Gadsden
E. L. Strandell, M. D. Brewton
John W. Davis, Jr., M. D. Montgomery
J. Garber Galbraith, M. D. Birmingham

State Health Officer
Ira L. Myers, M. D. Montgomery

Delegates and Alternates to the American Medical Association

(Terms expiring December 31 of year shown.)

1970
Delegate—E. Bryce Robinson, Jr., M. D., Fairfield
Alternate—W. E. White Anniston

1971
Delegate—M. Vaun Adams, M. D. Mobile
Alternate—E. L. McCafferty, Jr., M. D. Mobile
Delegate—P. W. Burleson, M. D. Birmingham
Alternate—Robert Parker, M. D. Montgomery

CONTENTS

President's Page 618

Among Alabama's Flying Physicians 623

The Woman's Auxiliary 624

The Month in Washington 628

Editorial Comment 632

- And Next Year Is Nineteen Seventy-One 632
- Headlines Can Harm Any Image—Including Medicine's 633
- Physician, Heal Thyself!—Or Take Your Medicine 634
- Guest Editorial—Professional Liability And Patient Care 635

Alabama Department of Public Health 637

- Intensified Tuberculosis Program In Tuscaloosa County 637

Legal Page:

- Professional Liability Insurance Contracts 646

Facts About Medicare Eligibility That Affect Your Pocketbook 647

Scientific Section 649

- Immunologic Psychology and Psychiatry, Wallace Marshall, M. D., Montgomery 649
- Pulmonary Function Testing For The General Hospital and Physician (Part II), D. S. Tysinger, Jr., M. D., Dothan 658

With Friends In Congress, GaMPAC Looks At Legislature 671

Internships, William C. Walley, M. D., Mobile 674

Around the State 688

- New Physicians Licensed to Practice in Alabama 688
- Vital Statistics 689

Hobbies to Fill A Doctor's Leisure 692

- The Merits and Mysteries of a Camera, W. A. Daniel, Jr., M. D., Birmingham 692

Recall of Contaminated Catheters Urged 694

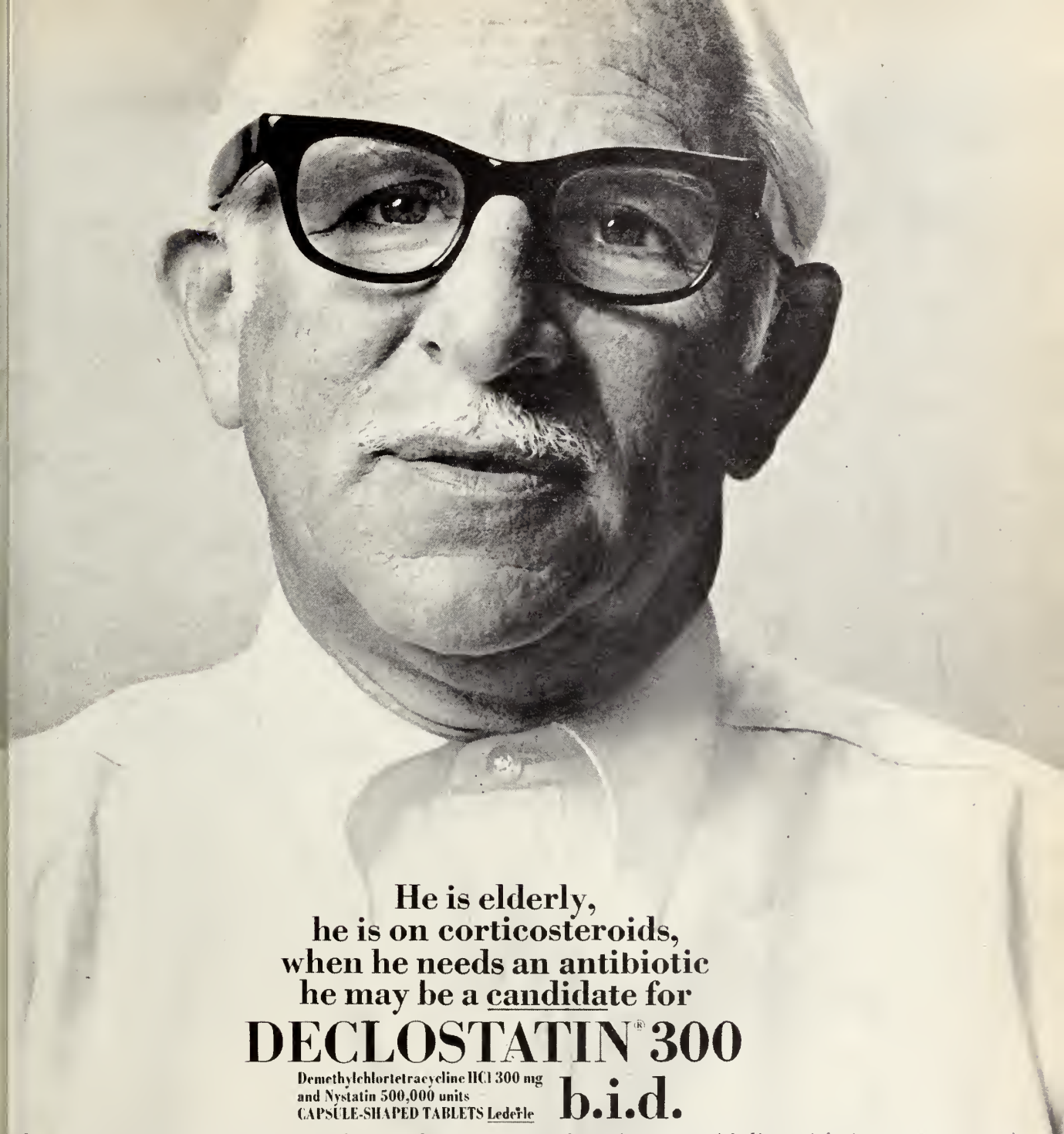
Fathers and Sons in Medicine 695

- The Arthur F. Tooles II and III, M. D., of Talladega 695
- States of Alabama and Florida Divide Alisons' Allegiance 696
- Three Becks, M. D., in Practice in Alabama 698

One 50-Year Club 'Recruit' Golfs 54 Holes A Week 703

Association Forum 704

- Development of Areawide Comprehensive Health Planning Agencies In Alabama 704



He is elderly,
he is on corticosteroids,
when he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

ırd susceptible patients against intestinal monilial over-
n during broad-spectrum therapy—the protection of
in is combined with demethylchlortetracycline in
OSTATIN.

your susceptible candidates, prescribe DECLOSTATIN
broad-spectrum therapy that prevents monilial
owth.

ndication: History of hypersensitivity to demethylchlortetracy-
nystatin.

g: In renal impairment, usual doses may lead to excessive accumu-
nd liver toxicity. Under such conditions, lower than usual doses
icated, and, if therapy is prolonged, serum level determinations
advisable. A photodynamic reaction to natural or artificial sun-
s been observed. Small amounts of drug and short exposure may
e an exaggerated sunburn reaction which may range from ery-
to severe skin manifestations. In a smaller proportion, photo-
reactions have been reported. Patients should avoid direct
e to sunlight and discontinue drug at the first evidence of skin
ort. Necessary subsequent courses of treatment with tetracy-
hould be carefully observed.

ions: Overgrowth of nonsusceptible organisms may occur. Con-
stant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES, A Division of American Cyanamid Company,
Pearl River, New York

846-8

President's Page

Summary Of Health Planning Efforts With Particular Reference To State Districting By Four Major Agencies

For functional purposes many organizations subdivide the State of Alabama. In the field of health various agencies employ differing area delineations. These often overlap and permit confusing uncoordination. Contemporary health planning effort is largely evolving through four media each of which is interested in cooperating with the others in sub-dividing the state. These are: 1. The Alabama Master Hospital Plan, 2. Regional Medical Program, 3. Comprehensive Health Planning and 4. Alabama Law 1126 (1969).

Alabama Master Hospital Plan

Some years ago the Hospital Planning Division of the Alabama State Board of Health developed the Alabama Master Hospital Plan which divided the state into seven Health Service Areas, each with established health service features and geographically related to major medical resources in Birmingham. These areas form a relatively balanced network of geography and people. Numerous agencies have affirmed the merit of this Master Plan. By law, the State Board of Health is the state agency responsible for administering the AMHP.

Comprehensive Health Planning

Comprehensive Health Planning came into being on November 3, 1966, when the President signed Public Law 89-749.

Section 2(a) of this law states "that fulfillment of our national purpose depends upon promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living; that attainment of this goal depends upon an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations; that federal financial assistance must be directed to support the marshalling of all health resources—national, state, and local—to assure comprehensive health services of high quality for every person, but without interference with existing patterns of private professional practice of medicine, dentistry and relating healing arts."

Section 2 (b) states "to carry out such purpose, and recognizing the changing character of health problems, the Congress finds that comprehensive planning for health services, health man-power, and health facilities is essential at every level of government; that desirable administration requires strengthening the leadership and capacities of State health agencies; and that support of health services provided people in their communities should be broadened and made more flexible."

Public Law 89-749 as signed added three new provisions to Section 314 of Public Health Service Act. Section 314 (a) provides federal funds for Statewide Comprehensive Health Planning; (b) provides funds for Areawide Comprehensive Health Planning and (c) provides funds for the training of health planners.

The purpose of (a) "is the development of a coordinated statewide system of health

planning which will permit and encourage maximum utilization of all health resources —federal, state and local. The law also is designed to seek development of new ways of delivering health services. The federal law provides for the designation of a single agency to be the Comprehensive Health Planning Agency for that state." In Alabama the State Board of Health is the single agency so designated. All applications for areawide planning grants under Comprehensive Health Planning must be approved by the State Board of Health in its capacity as Planning Agency before the Public Health Service can consider funding. This Agency (State Board of Health in Alabama) is required by law to establish an advisory council, at least one-half the members of which shall be consumers of health services.

Section 314 (b) is concerned with "Areawide Health Planning." Here the word "Area" means a part of a state or even a part of two adjoining states. In most instances such areas will include several counties except in large metropolitan districts. The intent of (b) is identical to that of (a) except that it relates to a smaller area. According to the law any public or non-private agency may apply for a grant to carry out areawide health planning. Area Health Planning Agencies also must have advisory councils with 50 per cent of their membership consumers.

Regional Medical Program

The Regional Medical Program came into being in 1935 through Public Law 89-239. Section 900 of this law states the purposes: (a) "Through grants, to encourage and assist in the establishment of regionally coordinated arrangements among medical schools, research institutions, and hospitals for research and training and for related demonstrations of patient care in the fields of heart disease, cancer, stroke and other major diseases; (b) to afford the medical profession and the medical institutions of the nation, through such corodinated arrangements, the opportunity of making available to their patients the latest advances in the diagnosis and treatment of these diseases; and (c) to accomplish these ends without interfering with the patterns, or the methods of financing, or patient care or professional practice, or with the administration of hospitals."

The principal emphasis of this program has been on the partnership between continuing education and research with the ultimate goal better patient care. In the state of Alabama the Medical College of Alabama was the applicant institution.

A state Advisory Committee for the Regional Medical Program, appointed by the Governor upon recommendation of the Medical Association of the State of Alabama, has lent its support and guidance. Much study and planning has been expended upon this program. Emphasis has consistently been on local participation and guidance with recognition of diversity of needs in each community.

After more than two years of study the Alabama Regional Program concludes that "the process of regionalization, and specifically the involvement of people and institutions, continue to make satisfactory progress only under a highly decentralized plan of action." The Alabama Regional Medical Program also has recently decided to assist in the formation of 314 (b) agencies (Areawide Comprehensive Health Planning Agencies).

The planned organizational structure to implement this policy of decentralization will be the local and multi-county Health Planning Council promoted by local physicians, hospital administrators and other health professionals. These councils are intended to assure that ARMP projects are tailored to meet local needs and to make the best possible use of local manpower and other resources. Health Planning Councils may be formed in each of the seven areas designated by the Alabama Master Hospital Plan and each Area may be staffed by at least one fulltime health planner. ARMP expects the Health Planning Councils to develop into Areawide

Comprehensive Health Planning Agencies as defined by Public Law 89-749.

The hope "is to unify the efforts of Comprehensive Health Planning and the Regional Medical Program in each of the seven areas, and to strengthen thereby the position of both. We believe, moreover, that such efforts operating directly under leadership of the Regional Hospital Councils and the developing Health Planning Councils, with sponsorship and advice of a broadly based committee of both providers and consumers of health services, placed outside of any individual hospital but with access to all, will have the best opportunity to succeed. In making this proposal, we are trying to anticipate such legal and administrative changes that are almost certain to come about in the near future. Even if these changes do not occur, the cooperative arrangements between the Alabama Regional Medical Program and the Comprehensive Health Planning Agencies are clearly within the spirit and letter of both pieces of legislature."

Alabama State Law 1126 (September 13, 1969).

This law provides for State Planning and Development Districts and Regional Planning and Development Commissions established by governing bodies of counties and municipalities and compatible with such state districts. The term district means "the geographical area designated by the Governor as hereinafter provided."

As defined by the Act a region "includes all geographical area contained within the aggregate territorial limits of all government units participating in a regional planning and development commission as hereinafter provided."

According to section 2 of this law "the Governor shall, within 12 months of the effective date of the Act, define and designate State Planning and Development Districts embracing all territory within the state." In designating the districts the Governor is required to consult with the governmental units concerned and to consider many factors such as community interest, homogeneity, geographic features, natural boundaries, patterns of communication, transportation, population and etc. In most instances the district will include at least three contiguous counties and contain a population of at least 100,000.

Section 3 (a) states that "at any time subsequent to the designating of the State Planning and Development Districts persuant to Section 2 of this Act, governmental units within the district, acting through their governing bodies by ordinance or resolution, may adopt a written agreement for formation of a Regional Development and Planning Commission and may petition the Governor to certify such a commission for a region located entirely within a state planning and development district and consisting of at least three contiguous counties and containing a population of at least 100,000."

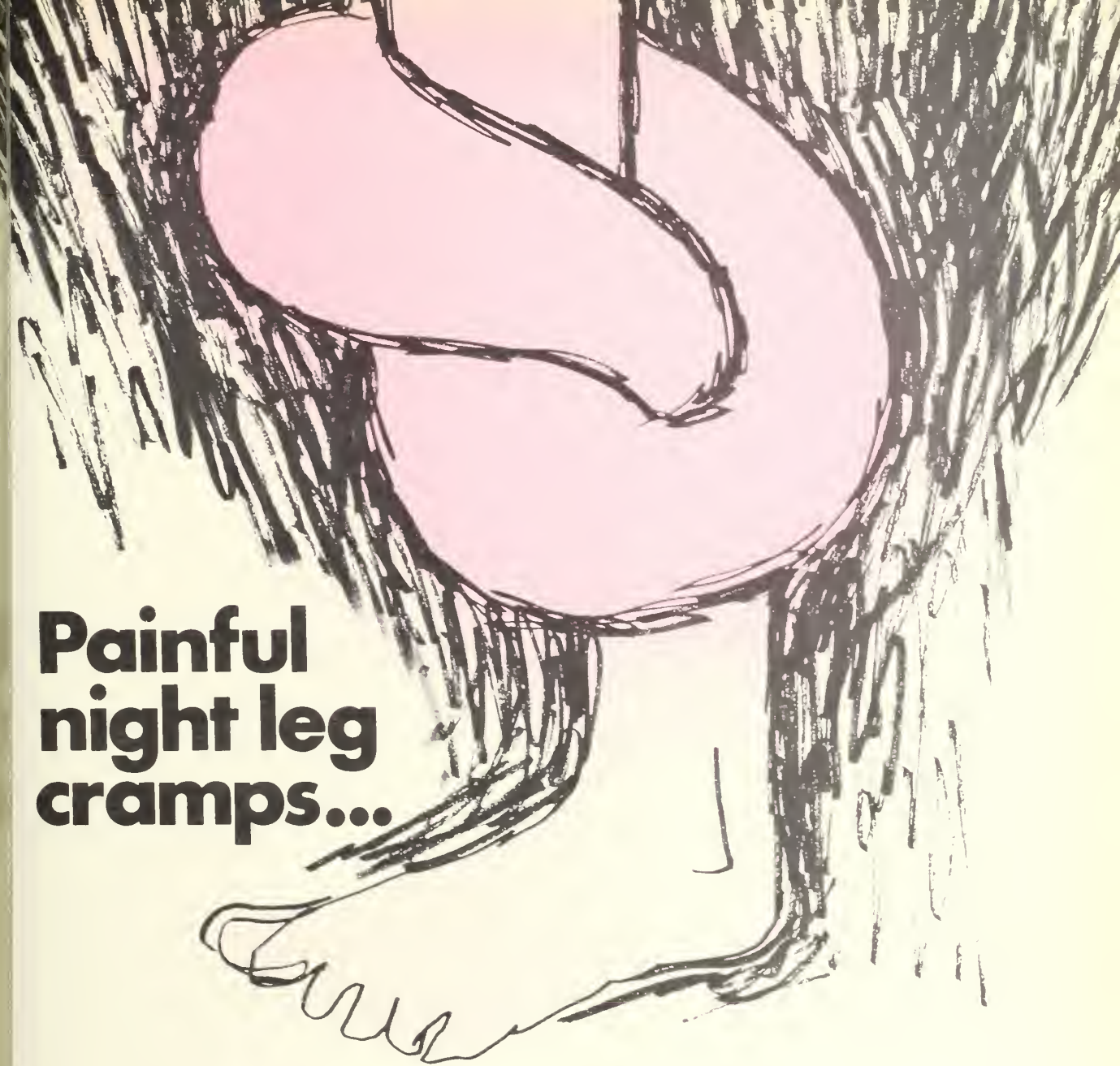
Section 4 delineates the composition of Regional Planning and Development Commissions and in addition to other requirements states that "all governmental units within the boundaries of a region which are parties to the agreement for the establishment of a Regional Planning and Development Commission shall be represented on the Commission as hereinafter provided."

Section 5 outlines the objectives and purposes of Regional Planning and Development Commissions and according to the law these number 14 and are rather comprehensive in pertaining to physical, economic and human resource development.

Section 6 indicates the organization of the Regional Planning and Development Commissions.

Section 7 stipulates that "State Planning and Development Districts designated under this act and Regional Planning Commissions established persuant to it shall, to the extent possible, be used as the basis for (1) State

(Continued on Page 623)



Painful night leg cramps...

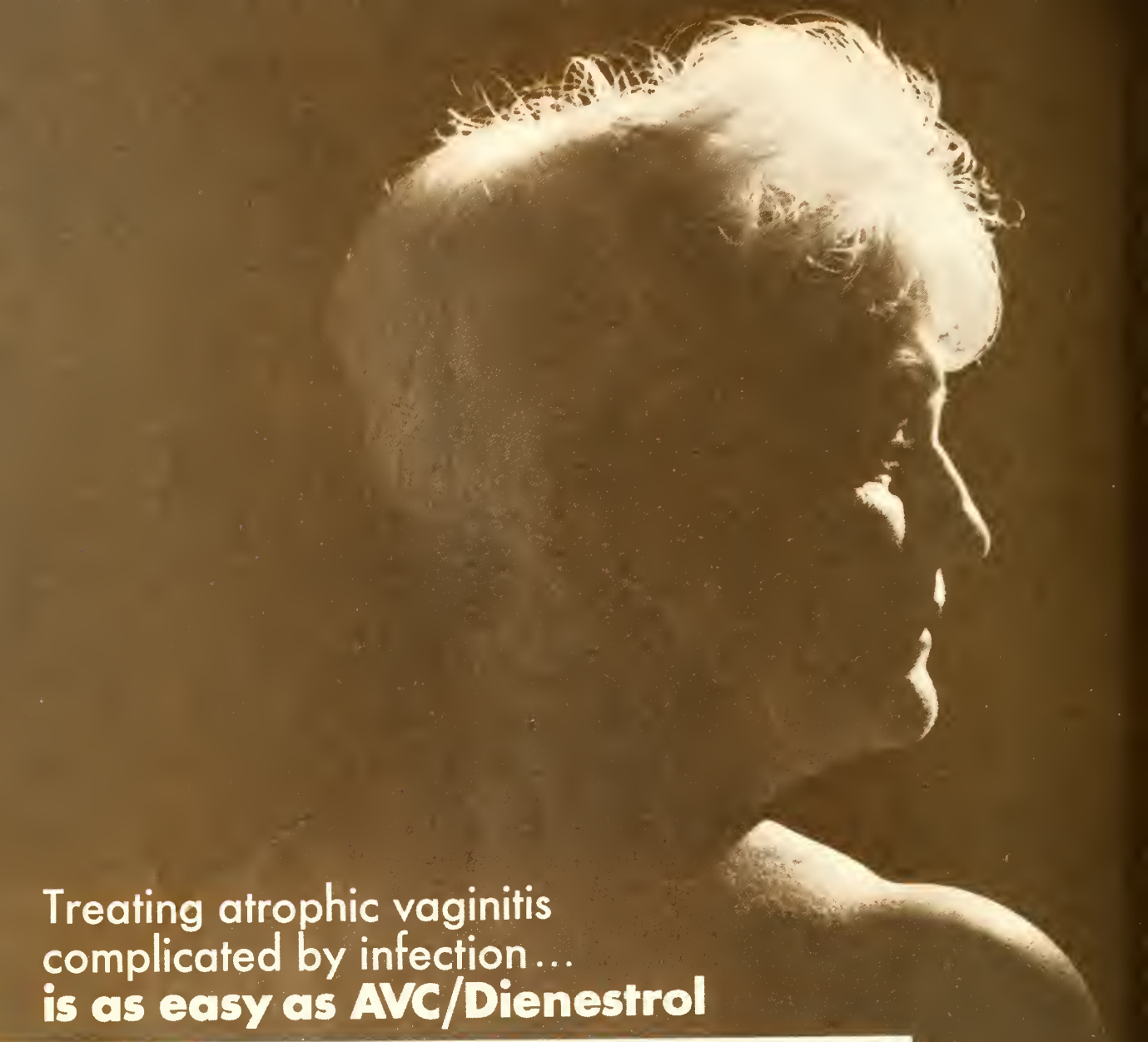
unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indicotions:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicase veins, thrombophlebitis, arteriosclerosis and static foot defarmities. **Controindicotions:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precoutions/Adverse Reoctions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosoge:** One tablet upon retiring. Where necessary dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™ Specific therapy for night leg cramps
(quinine sulfate 260 mg., aminophylline 195 mg.)



Treating atrophic vaginitis complicated by infection... is as easy as AVC/Dienestrol

Dienestrol helps restore estrogen-deficient vaginal mucosa. It is the *particular* ingredient in AVC/Dienestrol that improves cell maturation counts[1,2] — helps stimulate the restoration of normal vaginal epithelium to resist infection.

Two recent studies reconfirm AVC/Dienestrol efficacy.[1,2] AVC/Dienestrol is proven effective against monilial, trichomonal, nonspecific bacterial vaginitis, and mixed infections.[1,2] AVC/Dienestrol combats infection, helps restore tissue resistance to reinfection.

So even in complex cases, the treatment can remain the same. Comprehensive. Effective. Easy as AVC/D.

Contraindications: Known sensitivity to sulfanamides; diagnosis or familial history of carcinoma of the genital tract or breasts; precarcinomatous lesions of the vagina or vulva; palpable uterine fibromyoma; mammary fibroadenoma; depressed liver function.

Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfanamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfanamide toxicity or sensitivity are reasons to discontinue treatment. The use of AVC/Dienestrol does not preclude the necessity for careful diagnostic measures to eliminate the possibility of neoplasia of the vulva or vagina. Manifestations of excessive estrogenic stimulation through dienestrol absorption may occur. These include uterine bleeding, breast tenderness, exacerbation of menstrual irregularity and provocation of serious bleeding in women sterilized because of endometriosis. Endometrial withdrawal bleeding may occur if use is suddenly discontinued.

Dosage: One applicatorful or one suppository intravaginally once or twice daily.

Supplied: 'AVC/Dienestrol Cream'—Four ounce tube *with* applicator. 'AVC' and 'AVC/Dienestrol Suppositories'—Box of 12 *with* applicator.

References: (1) Salerno, L. J., Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. (2) Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

AVC/Dienestrol

Cream (dienestrol .01%, sulfanilamide 15.0%, aminacrine hydrachloride 0.2%, allantoin 2.0%)
Suppositories (dienestrol 0.70 mg., sulfanilamide 1.05 Gm., aminacrine hydrochloride 0.014 Gm., allantoin 0.14 Gm.)

TRADEMARK A V C AV-920A 7/69

(Continued from Page 620)

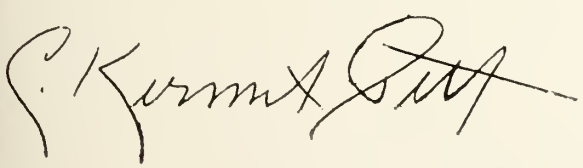
Planning and Programming, (2) Proposing or designating areas for the purpose of administering programs which receive aid under federal acts which requite districts and (3) for forming areawide planning including review and comment on projects, coordination and informational services for state and federal grant-in-aid programs."

Summary and Conclusion

This has been an effort to briefly describe the four major contemporary health planning entities of the State of Alabama and particularly, to indicate some of the related terminology used by each. The Alabama Master Hospital Plan designates seven Health Service Areas; Comprehensive Health Planning speaks of a Single State Comprehensive Health Planning Agency and Areawide Health Planning Agencies with Advisory Councils for each; the Alabama Regional Medical Program contemplates Health Planning Councils; and Alabama Law 1126 provides for State Planning and Development Districts and Regional Planning and Development Commissions.

Simplicity, efficiency, economy and reason implore unification of these planning agencies with their terms.

Since allocation of state and federal health care funds will probably soon be contingent upon recommendation or approval of Areawide Health Commissions, the origin and composition of these commissions will be most significant.



C. Kermit Pitt, M. D.

Among Alabama's Flying Physicians

The 23 Alabama doctors who are card-carrying members of the Flying Physicians Association are only a fraction of those who may affix their snake-entwined staff of Hermes to the fuselage of an airplane. There are half a dozen doctors in Mobile alone who are air enthusiasts in addition to the two FPA members.



Dr. L. L. Brown

One of the latter two is Leland L. Brown, M. D., in general practice in Alabama's Port city.

Dr. Brown's interest in airplanes preceded by years his choice of medicine for a profession. He soloed in 1932, at the age of 16. And he is married to the former Evelyn Kennedy, a graduate nurse, holder of a private pilot's license.

Dr. Brown took his premed at the University of Alabama, where he received his baccalaureate, and his MD is from the University of Tennessee, dated 1942. He interned at hospitals in Mobile and Memphis, and in addition to the Flying Physicians Association, is in Aerospace Medicine, the Civil Aviation Medical Association, Air Medics Association; is a member of the Aircraft Owner and Pilot Association, and of the "Live Cowards Club," a fun group composed of those who have sacrificed their airplanes to live, and of which there are only 13 living members.

The Woman's Auxiliary

President, Mrs. Ben H. Johnson, Jr.
President-Elect, Mrs. Howard C. Johnson
Northeast District Vice President, Mrs. James D. Holliman, Jr.
Northwest District Vice President, Mrs. Gene Qualls
Southeast District Vice President, Mrs. George Andrews
Southwest District Vice President, Mrs. Andrew D. Henderson
WAMASA Editor, Mrs. William L. Smith

AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the Medical Association of the State of Alabama. I will support its activities, protect its reputation and ever sustain its high ideals."

A visit to Decatur when the Morgan-Lawrence County Auxiliary met with several members of the Limestone County Auxiliary was a high spot for me. Not only from this group comes Belle Chenault, our gracious and loved national president, but also Rae Hansberry, state legislative chairman, and Zelda Pitt, the charming wife of your president. A lovelier group will not meet the eye every day. It was a refreshing experience to meet with these enthusiastic and good-looking Auxiliary members.

We attended the Calhoun Medical Society Annual Medical and Surgical Seminar in Anniston and what a treat this was. The dinner program was sensational and it is always fine to be with good friends again.

All of these friendly contacts sustain me as I do a slow burn and read an article in the September issue of McCall's Magazine entitled "Never Marry a Doctor." Not only is the doctor a target for the American press, the federal government, Internal Revenue, a victim of malpractice suits, and what have you, now the doctor's wife must add to the pack of critics. Actually the article did not have much depth and was for the most part a "gripe" session, but it pictures the doctor's wife as discontented, neglected, and unhappy. Most of the criticisms were from those no longer fortunate enough to still be married to doctors. Nevertheless the NEVER MARRY A DOCTOR on the front cover of the magazine did, I am sure, meet the intent of the publisher and sell hundreds of copies of the magazine.

Of course we do not keep from "nine to five" hours and there are many interruptions at meal time and "family" times, and doctor husbands are out of pocket when



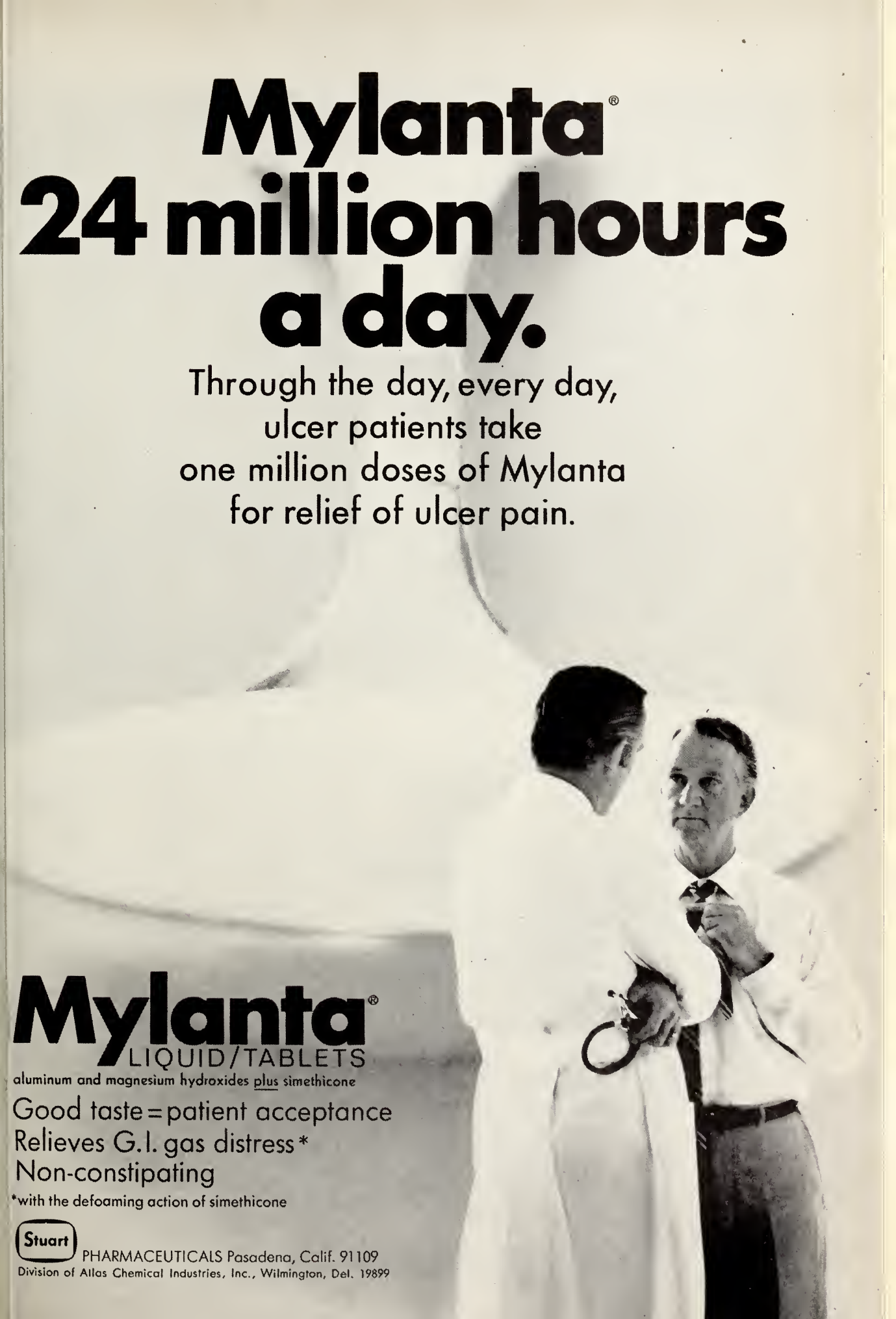
Mrs. Ben H. Johnson

needed often, but then what profession leaves a man around the house all day to meet unexpected emergencies, and who wants one there all the time anyway? At least we know where he can be located and this may not be said of many. The minor irritations that come with the profession are just part of it; and for 30 years I have considered myself fortunate to be married to a doctor and to have doctors and their wives and families as our friends. I should like to have a count of these disgruntled ones to see how many were active Auxiliary members. They should

(Continued on Page 626)

Mylanta®
24 million hours a day.

Through the day, every day,
ulcer patients take
one million doses of Mylanta
for relief of ulcer pain.



Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides plus simethicone

Good taste = patient acceptance
Relieves G.I. gas distress*
Non-constipating

*with the defoaming action of simethicone

Stuart PHARMACEUTICALS Pasadena, Calif. 91109
Division of Atlas Chemical Industries, Inc., Wilmington, Del. 19899

(Continued from Page 624)

have heard the President of the Woman's Auxiliary to the Student American Medical Association as she spoke of how joining this group changed her whole outlook on life as a wife who must move about with her husband.

We have a great degree of independence and most of us who are lucky enough to marry a doctor know ahead of time just what to expect and take it in stride as just part of the job of being married, whether it be to a doctor or whatever. Doctors' wives are very smart girls, for the most part, one has to be to get a doctor in the first place, and as I always say "if you can't stand the heat, better stay out of the kitchen."

I earnestly invite comments on this subject and would welcome some exchange of ideas, as this would give me some content for an article of my own. I should like to write "How lucky can we be, the doctors in our lives are Grr-eat!!"

In Bessemer we have our own Auxiliary, called the Bessemer Branch of the Auxiliary to the Jefferson County Medical Society. We are one hundred per cent in membership and an active group with many projects. It is customary for the local Auxiliary to honor the state president in some way, but gifts cost only money, so my Auxiliary members honored me with a Tea to which were invited their friends and mine (everybody in Bessemer) to recognize the third state president from Bessemer. The others were Mrs. Fred Denson (deceased) and my good friend, Mrs. Joe Horn. Not only did these girls give of their money, but of that precious commodity "time." I loved it, and am I not the lucky one!!!



(Mrs. Ben H. Johnson, Jr.)
President, WAMASA

Venezuela Fights To Live

Chagas' heart disease is a threat for 35 million people in Latin America where it is responsible for a great number of deaths. In Venezuela there are said to be one million cases, which would amount to one-tenth of the country's population . . .

The main carrier of the disease in Venezuela is the insect *Rhodnius prolixus* . . . It is nothing short of a national problem . . .

There unfortunately is no known remedy or treatment for Chagas' disease. Efforts to fight the scourge are centered on the use of pesticides against insects known to carry the parasite. The disappearance of poor housing conditions, the interruption of transmission and improved standards of living will be decisive factors in the struggle against it.

—*World Health*

Con-
ven-
ience!

Dicarbosil®
ANTACID

Your ulcer patients and others will praise it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

Doctor, after all we've been through together...

abscess
acne
amebiasis
anthrax
bacillary dysentery
bartonellosis
bronchitis
bronchopulmonary infection
brucellosis
chancroid
diphtheria
endocarditis
genitourinary infections
gonorrhea
granuloma inguinale
listeriosis
lymphogranuloma
mixed bacterial infection
osteomyelitis
otitis
pertussis
pharyngitis
pneumonia
psittacosis
pyelonephritis
Rocky Mountain spotted fever
scarlet fever
septicemias
sinusitis
soft tissue infection
tonsillitis
tularemia
typhus fever
urethritis

...don't you think it's time we were on a first-name basis?

call me "Achro® V"



Every pharmacist knows ACHRO® V stands for ACHROMYCIN® V

raindications: Hypersensitivity to
cycline.
aring: In renal impairment, since
etoxicity is possible, lower doses
dicated; during prolonged therapy
der serum level determinations.
odynamic reaction to sunlight may
r in hypersensitive persons.
osensitive individuals should
l exposure; discontinue treatment
n discomfort occurs.
autions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).
Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage. Upon adverse reaction, stop medication and treat appropriately.

Achromycin® V
Tetracycline

Lederle LEDERLE LABORATORIES • A Division of American Cyanamid Company, Pearl River, New York 10965

484-9



The Month in Washington

From the Washington Office
American Medical Association

Washington—A Senate subcommittee said that the number of medical malpractice suits probably will increase and "the situation threatens to become a national crisis."

Sen. Abraham Ribicoff (D., La.), chairman of the Subcommittee on Executive Reorganization which has been reviewing the federal role in the nation's health care problems for nearly two years, reported eight conclusions after an extensive staff study. They are:

"1. The number of malpractice suits and claims is rising sharply in certain regions of the country. The size of judgments and settlements is increasing rapidly.

"2. Most malpractice suits are the direct result of injuries suffered by patients during medical treatment or surgery. The majority have proved justifiable. These suits are the indirect result of a deterioration of the traditional physician-patient relationship.

"3. The publicity given to higher malpractice judgments and settlements, based frequently on new legal precedents, is likely to trigger increasing litigation in other States. The situation threatens to become a national crisis.

"4. Already, higher judgments and settlements are having the following direct results:

(a) Companies providing malpractice insurance are increasing the cost of coverage.

(b) These costs—in the form of higher charges—are being passed on to patients, their health care insurance companies, and federal health care programs.

"5. The rising number of malpractice suits is forcing physicians to practice what they call defensive medicine, viewing each patient as a potential malpractice claimant. Physicians often order excessive diagnostic procedures for patients, thereby increasing the cost of care. Moreover, they are declining to perform other procedures, which in themselves, may entail some risk of patient injury.

"6. At present, it appears that no one affected by the rise in malpractice suits and claims has been able to deal with this problem in a manner that promises to alleviate this situation.

"7. The lion's share of the total cost to the insurance companies of malpractice suits and claims goes to the legal community.

"8. There is a definite federal role in the malpractice problem."

Specialists listed as having "a greater potential exposure to malpractice suits" were orthopedic surgeons, general surgeons, neurosurgeons, anesthesiologists, obstetricians and gynecologists.

The 1150-page report included responses from staff inquiries to the American Medical Association, the American Hospital Association, lawyers and malpractice insurance companies.

If the situation continues to worsen, the report said, the federal government "may have to consider . . . a reinsurance pool to which it would contribute."

If the federal government moves into the malpractice area, the report said, it also should consider:

". . . whether medical or surgical injury to a patient is a community responsibility and therefore compensable by the community.

". . . whether it must provide legal aid to

the poor to help them seek redress from personal medical or surgical injury.

". . . whether it will insist upon creation of more effective regulatory devices over health professionals and health facilities to assure that those who are providing care are competent to do so."

* * *

A special task force recommended that the federal government experiment in different ways of paying physicians under medicare and medicaid.

In the first of a series of reports on medicaid, the task force—appointed by Health, Education and Welfare Secretary Robert H. Finch last July—said:

"HEW should actively program experiments for incentive reimbursement under medicare and medicaid, with new emphasis on experiments in payment methods for physicians as the key generators of health services. In addition to experiments in institutional reimbursement, other experiments could emphasize compensation to groups of practitioners using modified approaches to capitation with built-in controls on quality and costs."

The report said that states also should be made aware of options now available under present laws and regulations in addition to the individual fee-for-service basis for payments to physicians. The report listed "contract payments with quality controls, case average methods, and fee for time."

The task force recommended that medicaid funds be used to finance group practice, neighborhood health clinics and home health care programs, particularly in ghettos and other low-income areas.

The recommendation was the core of a goal "to effect changes and improvements in the health care delivery system" of the nation.

"Bringing about needed major changes in the organization and delivery of health services is a long-range objective, requiring national commitment and establishment of national policy and priorities," the task force said in the first of a series of reports.

"For the short-range, we are recommending certain actions which could bring about some improvements and which are consistent with long-range objectives."

For the short-range, it was recommended that five per cent of federal medicaid funds be earmarked for state "development and improvement of health care services and resources." Consideration also should be given to such use of medicare funds, the report said.

The federal government was urged to take a more positive leadership role in the medicare program by first improving its own administrative machinery and then getting the states to make their management functions more efficient.

Other recommendations of the task force included:

—Deny federal medicaid funds to chiropractors and naturopaths.

—Require uniform provisions and unified state standard-setting, certification, and consultation functions with respect to providers of service under both medicaid and medicare.

—Establish eligibility for medicaid benefits by permitting an applicant to fill out a simple declaration form.

—Require "profiles at the state level of vendors and recipients of service, and criteria against which to screen claims to identify patterns which appear to deviate from desirable and/or usual behavior."

* * *

The American Medical Association urged Congress to give top priority to appropriations that will help increase the number of physicians.

Testifying before a Senate appropriations

subcommittee, Dr. C. H. William Ruhe, director of the AMA's Division of Medical Education, said that "medical education should be supported financially as fully as possible to meet the pressing need which exists today for an increased number of physicians."

"We believe," he said, "that in any appropriation priorities established for all government programs, those which affect health care should be given primary consideration. Further, because of the special need . . . for more physicians, we urge that appropriations relevant to the production of physicians be given first priority."

Concerning decreases in the Administration budget in support of research and training grants, fellowships, library grants and research facility construction, the AMA spokesman said:

"It is difficult to estimate the effect these reductions will have upon efforts to increase physician production, but there is concern among many medical educators that the growth in medical school enrollments will be inhibited. We believe that this effect should be watched closely and corrective measures instituted promptly if physician production is impaired."

The AMA joined the Student American Medical Association and the Association of American Medical Colleges in a joint statement which said that "an increase in the appropriation for the Health Professions Student Loan Program is crucial."

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: MRS. ELIZABETH HARKINS, ACSW, *Coordinator of Admissions* or

CHARLES W. NEVILLE, JR., M. D., *Assistant Professor of Psychiatry and Medical Director*

Area Code 704 - 254-3201

Now available to members of

THE MEDICAL ASSOCIATION STATE OF ALABAMA

and their immediate families

MAJORCA: THE PEARL OF THE MEDITERRANEAN

majorcan carnival



Enjoy eight days of Spanish festivity and secluded peace on Majorca. Hidden away from the hustle and bustle of the Mediterranean travel trade, you will delight in the romantic rhythms of guitars, hear the click of flamenco heels, and relax by her sunbathed cobalt seas.

DISCOVER THE UNSPOILED BEAUTY OF MAJORCA

$349 complete per person
double occupancy
plus 19.50 tax and services
via Overseas National Airways
(a certificated supplemental carrier)

Everything's Yours!

- Round trip jet flights with first class food and beverages served aloft
- DELUXE ocean-front accommodations at the Melia Mallorca Victoria Fenix or other deluxe hotel
- All transfers
- Hotel gratuities and services
- Cocktail parties and surprise fun evenings
- Sightseeing tour of PALMA the spicy Spanish city with shopping bargains galore
- Hospitality desk at your hotel with our experienced Carnival staff at your service
- Optional side trips at low prices
- Carnival tour escort throughout
- NO REGIMENTATION — You are free to do as you please, when you please

PLUS! Elegant Dining

- Full American breakfasts daily at your hotel
- Gourmet dinners nightly
- Gala farewell banquet

DEPARTURE DATE: JUNE 13, 1970/DEPARTURE POINT: BIRMINGHAM, ALABAMA

THE MEDICAL ASSOC. STATE OF ALABAMA/19 So. Jackson St./Montgomery, Ala. 36104
(205)263-6441
Gentlemen

Enclosed please find $_____ ☐ as deposit ☐ as payment in full for _____ (No. of people). Make check or money order payable to: MAJORCAN CARNIVAL

$100 minimum deposit per person. Final payment due 30 days before departure.

NAME _____ PHONE _____

STREET _____

CITY _____ STATE _____ ZIP _____

DEPARTURE DATE _____ DEPARTURE CITY _____

Return this reservation immediately to insure space. Reservations limited. Rates based on double occupancy. Single rates $50 additional.

☐ Please send me your Majorcan Carnival brochure.

© Copyright 1969, AITS, Inc.



And Next Year Is Nineteen Seventy-One

Christmas was last month. New Year's was last Thursday, providing the presses turned on time.

And last Thursday, just after midnight, all of us—literally or figuratively—looked out the window, into the dark, and wondered: What now? Where now?

Seven of the 20th century's ten decades are behind us. The eighth is just beginning. And a lot of water has flowed over the dam and under the bridge in the passage of 70 years.

Those born in 1900 can remember the first automobile they ever saw. A span of beautiful horses was still the pride of the affluent. Barns and stables, public and private, were everywhere and there were no garages. Yellow fever had not yet retreated into history in Mobile and Montgomery, and a silk flag of that dread color warned visitors away from infected homes. Quarantine placards labeled houses where the contagiously ill lay, both the color and the type proclaiming what it was—Diphtheria, Small Pox, or whatnot.

January, named for the two-faced Roman god some seven centuries before Christ, was not originally the first month of the year. In fact, just 200 years ago, our forebears in this country would be waiting until March 25th to celebrate the first day of the New Year!

What now? Where now?

And it doesn't matter when. As the French novelist, essayist and dramatist Francois Mauriac said: "It is useless for me to remind myself that this day was chosen from among others by a mere pact among men. I find it impossible to work, impossible to read, for here in the room with me is the tall, veiled figure of the unknown year . . .

"We should not be so much concerned to know if war or peace, disgrace or glory, is hidden in these dark folds, or even to know if our greatest adventure, our own death, will take place at dawn or dusk on a particular day out of the 365 that lie ahead. For the folds of the cloak do not conceal from us the one thing that counts:—how we are inwardly prepared to welcome this silent phantom. This day is the day for each of us to assess our own strength, in utter silence to plumb the depths of our spirit."

And then Mauriac concludes with this challenge:

"May the immense unknown of this New Year find no weakness in us. All that is already stirring under the half-parted cloak is a danger that threatens the still unknown pain as well as the pleasure that debases and the success that blights.

". . . We must be prepared to accept pain, pleasure, and success—to accept them without perishing in them."

A belated healthy, happy, prosperous New Year—as of last Thursday—to every reader of The Journal of the Medical Association of the State of Alabama. Even if we can't look ahead and know: What now? Where now?

Headlines Can Harm Any Image—Including Medicine's

If reading is truly becoming a lost art, if the average American rarely gets beyond the top headlines, and if Vice President Agnew is right, then the combination of these three truths is a major menace to medicine's image.

Take a quick look at these headlines and see, if you were a layman without conviction, what kind of an image you would come up with:

AMA's Malaise Laid To Political Activity . . . More Health Laws Loom If MDs Sit By . . . Medicare Doctors' Bills Seen Forcing Fee Hike . . . The Doctors' Loophole . . . Study Shows Doctors Snub Needy Areas . . . $25,000 Medicaid Payments To A.M.A. Aides Are Reported . . . The Doctor Who Refused To Help . . . Finch Blames Doctors For Medicaid Cost.

Exclaims a Chicago Tribune Headline: "Medical Costs Soar So High Sickness Becomes a Luxury," while the more dignified New York Times observes solemnly: "Senate Tax Panel Asks Doctor Curb."

Away last summer the Washington Star was proclaiming in a three-column headline: "Caduceus at AMA Meeting Turning Into Dollar Sign," while the Chicago Daily News wondered in display type: "Can You Still Afford to be Ill?" and answered its own question in a subhead: "Medical costs highest in history and getting higher as nation strives to discover a way out of the crisis."

In a single syndicated column, presupposing there are some who still get beyond the headlines, Jack Anderson (a worthy successor to the late Drew Pearson) charged: "The Nation's 7,200 hospitals are taking in their share of the profits from sickness and death," adding that these "Hospital costs are multiplied by the featherbedding practices of the American Medical Association," and concluding that: "Much of the blame for bewildering hospital costs comes from the cheek-by-jowl love affair between the Blue Cross and the hospitals."

Put these samples all together, spice liberally with soap operas in a medical setting, embrace it all neatly in package prepared for us (according to Vice President Agnew) by a compact, irresponsible group of TV executives and commentators, and see what you come up with, in the way of a present-day image of Medicine.

For never forget, that according to the latest polls as reported in the Chicago Daily News:

"Television is . . . the most believable news medium. Up from 41 per cent most believable in 1967, TV now leads newspapers 2 to 1 in response to the question of which news version an individual would be most inclined to believe. In the initial year of the survey newspapers were the most believable medium."

Of course, one might add that "publishers accused the surveyors of outright lying."

But that intra-fraternity dispute has little to do with the damaged medical image.

Drug Abuse To Decline

Drug use as we know it today will, undoubtedly, decrease; that is the lesson of history. The decrease will be best and most swiftly effected if professionals make their opinions known. The "over thirty" generation's error has not been that it does not practice what it preaches, but, as *Fortune Magazine* put it recently, that it does not preach what it practices.

Rocky Mountain Medical Journal

'Physician, Heal Thyself!'—Or Take Your Medicine

What will you have: orange juice or half a grapefruit?

Tastes are as unequal as people, as doctors.

Some MDs choose a small town with a rural practice, others prefer the bustle of the big city. Some like a general practice, others a specialty. Some like the pooled resources of group practice, others the cloistered responsibilities of a medical college, and more are attracted and held by the independence of their profession.

Orange juice or half a grapefruit?

It doesn't really matter. What *does* matter is the power to choose. The idea of being ordered to eat half a grapefruit because the supply of available orange juice is limited or because orange juice is preferred by a group of more favored citizens is something repugnant to us all.

No doctor who wants to practice internal medicine wants to be ordered into the field of gynecology simply because the internists are many and the gynecologists few, into orthopedic surgery because the psychiatrists are considered numerous enough.

There are doubtless some doctors who would rationalize the encroaching regimentation, who would enjoy taking their turn at the sickbed or in surgery, as their number came up, and so long as their own immediate families remained in good health.

This message is not for these.

It is only for those who value the power to choose, regardless of their particular taste-buds.

Orange juice or half a grapefruit?

Sleepy Drivers Cause Accidents; 50,000 To Die In '70

Americans who will die in automobile accidents in 1970 will top the 50,000 mark, as they did in 1969 and in 1968.

And a major cause of these fatal accidents is the sleepy driver, declares the lead article in a recent issue of *Mayo Clinic Proceedings*, carrying the byline of Robert E. Yoss, M. D., Section of Neurology.

Dr. Yoss proposes a method, based on preliminary data, of discovering in advance of accidents those most apt to fall asleep and cause them. The plan makes use of the discovery that when a person is alert his pupils are large, when he is asleep they are small, and when he is tired or drowsy or very sleepy, the eye pupils are intermediate.

The article cites half a dozen case histories and concludes:

"There is a need to detect abnormalities in operators of motor vehicles which might cause or contribute to vehicular accidents. The driver who tends to lose alertness or gets sleepy easily is in such a category. To our knowledge the only present method capable of detecting the sleepy driver is pupillography, since spontaneous changes in pupillary size and behavior appear to reflect accurately one's state of wakefulness."

Guest Editorial

Professional Liability And Patient Care

The escalating cost of professional liability insurance which practicing physicians in California must bear reflects a situation which can only have profound effects on the quantity, quality and cost of patient care. The problem is underscored at this time by the fact that thousands of physicians had their premiums a little more than doubled, beginning first of October, and for some specialists these premiums amount to several thousands of dollars a year. The number of malpractice suits is increasing, the costs of litigation are rising, some of the awards are becoming astronomical (there are several over a million dollars), and quite understandably there is a notable lack of enthusiasm in the insurance industry to rush into this sort of business, particularly when carriers have no sure way of knowing how long after an incident a suit may be filed or what the going rate for awards may be when it is settled.

The causes of all this are complex. Physicians know that there is a risk of untoward reaction or a poor result in almost everything they do, no matter how well they do it. It is true that as science advances and new and better treatments become available, these are often more dangerous and carry greater risks. Yet when an unfortunate result occurs, the courts are apt to hold "the thing speaks for itself" (*res ipsa loquitur*) and the defendant physician finds himself in the factual position of being guilty unless he can prove himself innocent, which seems somewhat unfair in these days when the presumption of innocence for even the manifestly guilty is so high on the legal agenda. There also seems to be a growing feeling abroad that everyone has a right to be healthy, that medical science now knows enough to make everyone healthy, and that when there is a failure it must be someone's fault. Experience shows that this approach can be costly. The traditional reluctance of patients to sue their physicians and the erstwhile reluctance of juries to hold the physician responsible when an unfortunate incident occurs, because he "tried to do his best," is becoming a thing of the past. We are living in a new era when the right to sue is being fully exploited by the public. One can only speculate concerning how much the peculiarly American custom of contingency fees for plaintiffs' attorneys may have to do with it.

There is no question that when a physician truly commits malpractice the unfortunate patient should receive fair compensation insofar as this is possible. This is the position of the medical profession, which long ago took steps to make qualified disinterested physicians available to testify in behalf of plaintiffs and so negate the so-called "conspiracy of silence." Through the mechanism of review and advisory committees medical societies have sought to determine if malpractice was actually committed as the plaintiff claimed, and, if there was malpractice, recommend that the suit be fairly settled, and if there was no actual malpractice that it be fought. There have also been many programs to reduce the causes of malpractice and of suits, the most recent being the highly successful "California Invitational." For several years the California Medical Association has sought relief through the Legislature, this in the public interest as much as for the physician. The first successful effort resulted in the "Good Samaritan Law," and other bills subsequently enacted have extended the principle of this law. Last year the Legislature passed several new laws dealing with the statute of limitations, privileged communications for medical society and hospital staff committee proceedings and records, and advance payments to an injured patient, without presumption of guilt, all of which were helpful. An experiment is being

tried with prior agreement to use arbitration. There is talk of something like "trip insurance" whereby insurance against a bad result would be purchased by the patient at the time of each hospital admission. There is discussion of a possible limitation on the extent of the professional liability of physicians, as is now the case with the liability of employers in industrial accidents. And it is intended that independent actuarial analysis will be sought of the underwriting experience, claim and loss projections and premium structure of all the principal professional liability carriers in the state, as has already been done with some.

But the escalating costs of professional liability insurance continue to race ahead of all these worthy efforts to control them. The impact upon the quality of patient care and its cost is now becoming serious. On the positive side there is no doubt that the ever-present threat of suit has tightened up many procedures and practices. But it has also led more and more to what has been called "defensive medicine," that is, those things a physician does or does not do in order to lessen his risk of being sued. The things the physician *does*, in this regard, often unnecessarily increase the cost of health care, and those he does not do may well deprive a patient of an opportunity to receive the latest and best in scientific care simply because the risk is more than negligible. Also on the negative side, it is obvious enough that all the costs of litigation and awards are ultimately paid by the public, although this basic fact is accepted reluctantly or not at all in some quarters.

In a larger sense some of the predictable effects on health care delivery may prove even more serious. For example, young physicians may begin to seek alternatives to starting in private practice because of an unbearably high cost of the professional liability insurance which they must have even before they can see a patient. And, even worse, what will be the action taken by physicians already in practice if the cost becomes prohibitive or if they are no longer able to get any insurance at all? This would mean that they would have to assume a personal risk of an adverse court judgment which might be for a million dollars or more. This is not mere speculation. There is already good evidence that a substantial number of physicians are beginning to take shelter from these problems, from the irritants of government interference with their practice and from other deterrents to fulfilling a personal direct responsibility for a patient's care, which is the very core of private practice. These physicians, often among the most capable, are seeking other avenues for their professional fulfillment. The lesson is too slowly being learned in a number of quarters that physicians are very much like other people. They go where the incentives are and avoid the deterrents.

The eventual effect of all these current trends upon the quality and quantity of patient care is impossible even to estimate. The forces described are among the many which could easily lead to the destruction of personal direct physician responsibility for individual patient care. It is hard to guess what the ramifications of this might be for the profession or for society, but it is equally hard if not harder to imagine how in the world the patient might ultimately benefit. The medical profession is doing all it can. Perhaps the time has come to give it some real help.

—Reprinted by Permission
California Medicine
Malcolm S. M. Watts, M. D., editor

Physician opening office in need of used General Practice equipment including diagnostic, laboratory and treatment items. Contact Jefferson County Medical Society or call 822-6687, Birmingham.

Alabama Department of Public Health

Intensified Tuberculosis Program In Tuscaloosa County

by Frank Bruce

Public Health Representative

Alabama Department of Public Health

During the month of April, 1969, an intensified tuberculosis program was conducted in Tuscaloosa County. The purpose of this program was to obtain a satisfactory disposition and bring or return to medical supervision every delinquent tuberculosis case recorded in Tuscaloosa's open registry.

As of Dec. 31, 1968, a total of 660 cases was recorded in Tuscaloosa County's registry. Of this number 79 were hospitalized for tuberculosis, 28 were in an institution for other reasons, and 543 cases were at home. Of the 543 cases at home(21 were listed as active, 65 were of undetermined activity, 50 were quiescent, and 407 were classified as inactive.

The program was organized and carried out in three phases, covering a period of nine days. Tuscaloosa County Health Department personnel worked closely with state health department personnel in implementing the project.

Results of the first phase, which consisted of identifying the problem, indicated that of the 660 tuberculosis cases recorded in the register, 230 were lacking current medical evaluation and/or supervision. Referrals were made on these delinquent patients in the following order of priority: active, quiescent, undetermined, and inactive.

To assist in the second or investigational phase of the program, a county map was constructed reflecting the areas of highest concentration of delinquent cases. From the 230 cases found to lack current evaluation, 175 referrals needing investigative work were initiated. The remaining 55 needed information exchanges from sources such as Bryce Hospital, Partlow State School, Kilby Prison, Atmore Prison, veterans administration hospitals, and private physicians. The second phase of the intensified program consisted of three days of field investigations. From these investigations, 118 appointments were set up for the third phase, a special out-patient clinic held by Dr. Life Barnard, U. S. P. H. S. Tuberculosis Control Medical Officer of the Mobile District.

A special effort was made by the investigators to talk individually with each delinquent active and quiescent patient. Two stamped sputum containers were left with each patient, and proper specimen collection instructions were also given to each person seen by the investigators. This was done to have current sputum reports available when the patients were seen by Dr. Barnard. It should be noted that the percentage of current sputum reports obtained exceeded 75 per cent. A number of the priority cases could not be contacted during the day due to work or for some other reason. Therefore, visits were made at night to reach these peo-

TUSCALOOSA COUNTY

TUBERCULOSIS CASE REGISTER INFORMATION	Before Program	After Program
Total TB cases recorded in open register	660	497
Cases hospitalized for tuberculosis	79	38
Cases in institutions for other reasons	28	23
Total cases at home	543	436
Active cases at home	21	12
Undetermined cases at home	65	22
Quiescent cases at home	50	61
Inactive cases at home	407	341
Percentage of active cases at home on drugs	52.4%	91.7%
Percentage of active cases at home with current bacteriology	56.3%	91.7%
Percentage of active cases at home with x-ray exam. in past 6 months	52.4%	91.7%
Percentage of quiescent cases at home on drugs	86.0%	88.5%
Percentage of quiescent cases at home with current bacteriology	62.0%	83.6%
Percentage of quiescent cases with x-ray in past 6 months	90.0%	98.4%
Percentage of activity undetermined cases at home on drugs	7.7%	50.0%
Percentage of activity undet. cases at home with x-ray exam. in past 6 mos.	21.5%	63.6%
Percentage of activity undet. cases at home with bact. exam. in past 6 mos.	10.3%	54.5%
Percentage of inact. cases at home with x-ray exam. in past year	69.8%	90.9%
Percentage of inact. cases at home with bact. exam. in past 6 months	35.5%	60.5%
Percentage of inactive cases at home on drugs	23.8%	39.6%

ple to explain the importance of current medical evaluation by a clinician. There were two weeks between the home visits and the time the clinics were to be held. To preserve the delinquent patients' enthusiasm created by the field visits, a reminder letter was prepared and sent to every patient who received an appointment.

Phase three of the program consisted of three days of out-patient clinics. The delinquent active and quiescent patients were scheduled for the first day to give the investigators an opportunity to revisit if they failed to keep their appointments. Inactive and undetermined cases were also given appointments during all these days. By the afternoon of the third day, several active, quiescent, and undetermined cases had not kept their appointments. By extending the clinic until 9:30 p. m. and intensifying the work of the investigators, all delinquent priority patients were seen and evaluated by Dr. Barnard. It should be noted that in some instances the investigators dressed patients' children and furnished transportation to induce patients to come to the clinic.

Upon arrival at the clinic, each patient was registered, a medical history taken, an X-ray taken and developed, and the patient seen by the doctor. After being seen by the physician and upon his orders, a tuberculin skin test

(Continued on Page 643)

Because any urologic infection can be serious, **BREON** introduces potent therapy

for the strong start and a fast finish...

"...a significant gap appears to have been closed in the armory of drugs available to the urologist."[1]
Bacteriuria and symptoms can be eliminated within 48 to 72 hours; susceptible infection often in 10 to 14 days.

before your "minor" becomes a major problem

choice initial treatment for urinary infections

Cybis® (nalidixic acid) provides prompt broad gram-negative bactericidal activity at normal urinary pH range that can eradicate troublesome *E. coli,* Aerobacter and Proteus. A good starting drug, it can effectively accelerate management of infection due to sensitive organisms.

essential control within the primary 72-hour cycle

In cases of acute infection due to susceptible organisms, Cybis works well toward the rapid clearing of disease when obstruction is absent or can be relieved. Within 48 to 72 hours, symptoms are frequently eased and bacteriuria eliminated. Susceptible infection is often eradicated in 10 to 14 days.

blocks the young female progression of infection

Cybis can be useful in naturally susceptible young female patients with new or well-established urinary disturbances. Combining rapid potency with relative freedom of serious side reactions and toxicity, the drug can be of particular value in preventing higher tract involvement or blocking the possible continuum of disease. (See Chart)

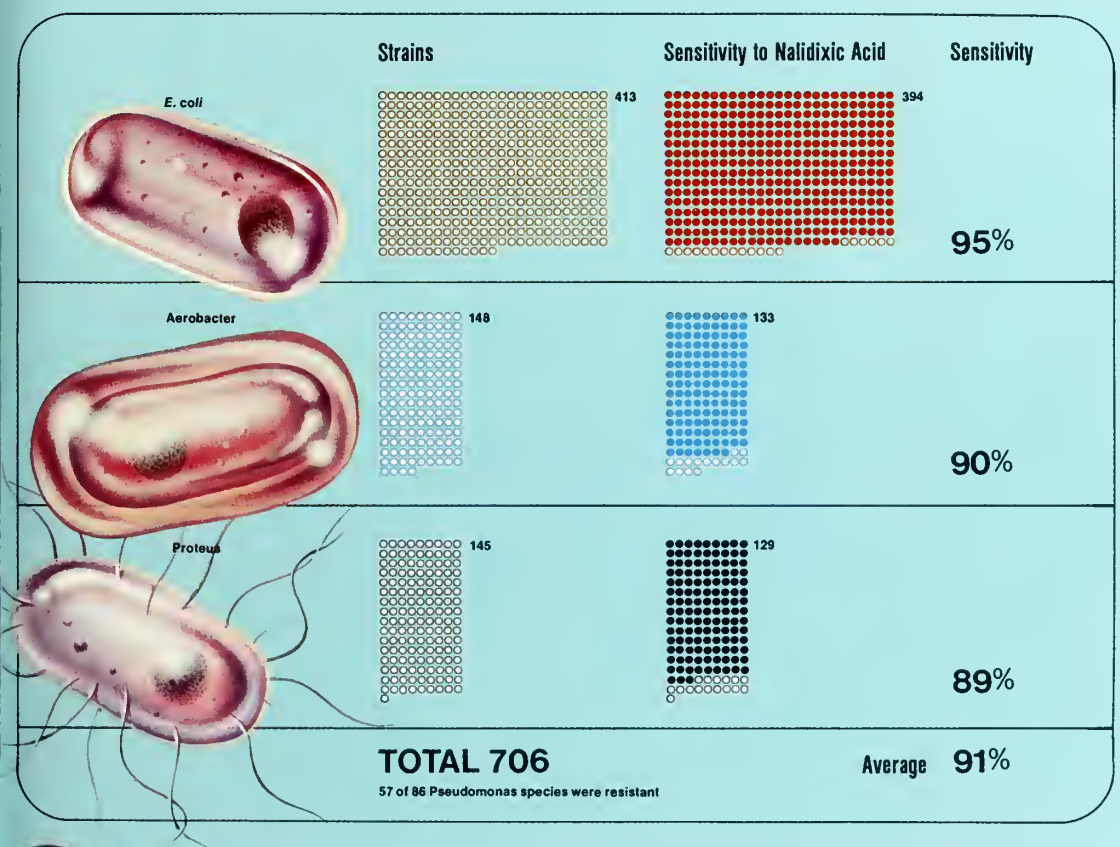
Kinetic Relationship of Acute and Chronic Bacterial Pyelonephritis to Chronic Renal Disease[2]



consistent activity against 706 gram-negative strains

In vitro testing of *E. coli*, Aerobacter and Proteus species showed better than 90% sensitivity to nalidixic acid.[3] (See Table)

Better Than 90% Sensitivity Among 3 Common Urinary Invaders



References: 1. Reimann-Hunziker, R. and Reimann-Hunziker, G. J.: *Praxis* 53:15, Jan. 9, 1964. 2. Sanford, J. P.: *Med. Times* 96:715, July 1968. 3. Reese, L.: *Canad. M. A. J.* 92:394-397, Feb. 20, 1965.

Cybis®
(nalidixic acid)

for the strong start and a fast finish... in cystitis, pyelonephritis, prostatitis, urethritis

Before prescribing, please consult complete product information, a summary of which follows on the next page, including indications, warning, precautions, adverse reactions and dosage.

Summary of prescribing information

Indications: Urinary tract infections in which species of sensitive gram-negative bacteria are predominant, particularly *Proteus, Escherichia coli, Aerobacter, Klebsiella,* and certain strains of *Pseudomonas.* Gram-positive bacteria are less sensitive to Cybis but favorable clinical results have been observed.

Warning: Use in Pregnancy. This drug is not recommended in the first trimester of pregnancy. However, it has been used in several patients during the last two trimesters without producing apparent ill effects in either mother or fetus.

Precautions: Although prolonged treatment with Cybis has been generally well tolerated, as with all new drugs it is advisable to carry out blood, renal, and liver function tests periodically if treatment is continued for more than one or two weeks. The dosage recommended for adults and children should not be arbitrarily doubled unless under the careful supervision of a physician. **It should be used with caution in patients with liver disease, epilepsy, or severe cerebral arteriosclerosis, and in patients in whom kidney function is severely impaired.** Patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving Cybis and, if a photosensitivity reaction occurs, therapy should be discontinued.

During treatment microorganisms may develop resistance to this drug. Resistant bacteria, not previously present or identified, may emerge. Cultures should be taken and bacterial sensitivity tests made periodically, particularly if the clinical response is unsatisfactory or if a relapse occurs. Should resistance develop, other specific chemotherapy should be instituted; no cross resistance has been observed. If new strains of bacteria that are not sensitive emerge, other effective antibacterial agents may be added. When Benedict's or Fehling's solutions or Clinitest® Reagent Tablets are used to test the urine of patients taking Cybis, a false-positive reaction for glucose may be obtained due to the liberation of glucuronic acid from the metabolites excreted. However, a colorimetric test for glucose based on an enzyme reaction (using, for example, Clinistix® Reagent Strips or Tes-Tape®) does not give a false-positive reaction to Cybis glucuronide.

Adverse reactions: Mainly mild nausea, vomiting, and other gastrointestinal disturbances: less frequently, sleepiness, drowsiness, weakness, headache, dizziness and vertigo, and rarely cholestasis, paresthesia, thrombocytopenia, leukopenia, or hemolytic anemia which in some patients may have been associated with deficiency in activity of glucose-6-phosphate dehydrogenase. Itching, pruritus, rash, urticaria, mild eosinophilia, reversible photosensitivity reactions primarily involving exposed surfaces, and reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), occurred occasionally. Reversible increased intracranial pressure with bulging anterior fontanel, papilledema, and headache have been observed occasionally in infants and children. Toxic psychosis and brief convulsions (the latter generally in patients with possible predisposing factors, and both usually associated with excessive dosage) have been recorded in rare instances.

Dosage and administration: *Adults*— Four Gm. daily by mouth (2 tablets of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily (1 tablet of 500 mg. four times daily). *Children*— According to age and weight: approximately *25 mg. per pound* of body weight per day, administered in divided doses.

Note: The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied: Tablets of 500 mg., bottles of 50.

Before prescribing, please refer to complete prescribing information.

Cybis®

(nalidixic acid)

for the strong start and a fast finish...
in cystitis
pyelonephritis
prostatitis
urethritis





BREON

BREON LABORATORIES INC.
90 Park Avenue, New York. N.Y. 10016
Subsidiary of Sterling Drug Inc.

(Continued from Page 638)

was performed, drugs issued and/or an aerosol sputum obtained. The average time spent by the patient from registration to dismissal by the clinician was approximately 30 minutes.

It should be mentioned that most patients were very difficult to get into the clinic. In most cases it had been quite some time since they had had an X-ray or any medical attention. In some instances the most recent diagnosis was in the early 1950's. Due to the rapport established by Dr. Barnard and other personnel, many patients left with a completely new outlook on public health services. It was a new experience for them to have all needs taken care of in one trip—X-ray, examination by the physician, drugs issued, and sputum collected. Most of the delinquent patients were familiar with the way the clinics were held in the past, such as no consultation with a physician and waiting several months for results from an X-ray. They were quite amazed at seeing their current and previous X-ray and having a physician point out any abnormalities.

Judging from the patients' acceptance of the services offered and the overall statistical evaluation of the program, the Tuscaloosa County intensified program was a success. A major factor in the success of this program was the joint effort and complete cooperation of the Tuscaloosa County Health Department and the tuberculosis division of the state health department. This type program could be used in other problem areas throughout the state. Such programs cannot end at this phase, however, but will need further efforts to keep this type patient under adequate medical supervision.

BUREAU OF PREVENTABLE DISEASES

Frederick S. Wolf, M. D., Director

Current Morbidity Statistics

1969

	Sept.	Oct.	*E. E. Oct.
Tuberculosis	92	92	110
Syphilis	51	48	117
Gonorrhea	501	643	362
Chancroid	0	1	1
Typhoid fever	3	0	2
Salmonella	46	16	13
Undulant fever	0	0	0
Shigella	20	17	14
Amebic dysentery	0	1	4
Scarlet fever & strep. throat	480	873	342
Diphtheria	2	1	3
Whooping cough	6	1	8
Meningitis	4	16	5
Tularemia	0	0	0
Tetanus	1	1	1
Poliomyelitis	0	0	0
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	2	0	16
German measles	3	7	2
Chickenpox	7	16	3
Mumps	9	11	12
Infectious hepatitis	21	38	43
Typhus fever	0	1	0
Rocky Mt. spotted fever	1	0	0
Malaria	5	1	0
Cancer	910	597	727
Rheumatic fever	5	11	15
Rheumatic heart	14	13	20
Influenza	66	85	36
Pneumonia	185	150	153
Rabies—Human cases	0	0	0
Pos. animal heads	0	2	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF LABORATORIES

Laboratory Combined Division All Report For Period October 1969

Thomas S. Hosty, Ph.D., Director

	No. Specimens Received
General Bacteriology	2,195
Virology	193
Parasitology	1,714
Enteric Bacteriology	374
Fluorescent Microscopy	5,703
Tuberculosis	5,448
Mycology	81
Milk and Dairy Products	5,817
Water	3,540
Sea Foods	143
Syphilis Serology	32,906
Special Serology	1,295
Metabolic Diseases	30,551
Cytology	3,488
Chemistries	193
Miscellaneous	753
Total Number of Specimens Received	94,394

BUREAU OF VITAL STATISTICS

PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA

Ralph W. Roberts, M. S., Director

SEPTEMBER 1969

Live Births / Deaths / Causes of Death	Number Recorded During 1969			Rates* (Annual Basis)		
	Total	White	Non-White	1969	1968	1967
Live Births	5,794	3,777	2,017	19.6	18.9	20.5
Deaths	2,589	1,741	848	8.7	8.7	8.2
Fetal Deaths	84	39	45	14.3	20.0	19.8
Infant Deaths—						
under one month	103	57	46	17.8	19.0	13.3
under one year	129	69	60	22.3	22.9	20.7
Maternal Deaths	3	1	2	.....	7.0	6.5
Causes of Death						
Bacillary Dysentery, amebiasis, 004, 006					0.3	0.3
Enteritis, other diarrheal diseases,, 008, 009	4	2	2	1.4	†	†
Tuberculosis, all forms, 010-019	12	2	10	4.0	3.0	6.1
Diphtheria, 032	.....	.....	.....	.....	.....	.....
Whooping Cough, 033	.....	.....	.....	.....	.....	.....
Meningococcal infections, 036	1	1	.....	0.3	.....	.....
Poliomyelitis (acute), 040-043**	.....	.....	.....	.....	.....	.....
Measles, 055	.....	.....	.....	.....	.....	.....
Syphilis, 090-097	2	.....	2	0.7	1.4	1.7
Malignant Neoplasms 140-209	417	291	126	140.7	137.1	122.6
Diabetes Mellitus, 250	36	26	10	12.2	15.2	13.0
Major cardiovascular diseases, 390-448	1,301	909	392	439.1	†	†
Diseases of heart, 390-398, 402, 404, 410-429	846	615	231	285.5	286.0	269.8
Rheumatic fever & heart 390-398	9	6	3	3.0	†	†
Hypertensive heart & renal diseases, 402, 404	32	19	13	10.8	†	†
Ischemic heart disease 410-414	687	516	171	231.9	†	†
Cerebrovascular disease, 430-438	362	232	130	122.2	116.8	116.8
Diseases of the arteries, 440-448	81	57	24	27.3	27.8	21.5
Influenza, 470-474	.....	.....	.....	.....	.....	0.3
Pneumonia, 480-486	48	36	12	16.2	16.2	14.0
Bronchitis, emphysema, Asthma, 490-493	27	23	4	9.1	†	†
Appendicitis, 540-543	5	3	2	1.7	.....	0.7
Hernia, intestinal obstr., 550-553, 560	12	7	5	4.0	4.1	3.8
Cirrhosis of liver, 571	24	18	6	8.1	6.8	7.2
Complications of preg., childbirth, 630-678	3	1	2	5.1	7.0	6.5
Congenital anomalies, 740-759	22	17	5	3.8	4.8	5.2
Immaturity, 777	32	16	16	5.5	3.6	3.7
Accidents, total, 800-949	213	150	63	71.9	68.0	63.5
Motor vehicle accidents, 810-823, 940	147	108	39	49.6	37.2	32.8
All other defined causes	311	192	119	105.0	123.9	110.3
Symptoms & ill-defined, 780-796	119	47	72	40.2	45.0	41.3

*Rates: Births and deaths—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

**Does not include late effects

†NOTE: The Eighth Revision of ICD (New Revised Code) is used beginning with January 1969. Comparison with statistics compiled under the former Code (Seventh Revision ICD) and rates cannot be made. Direct to the Alabama Bureau of Vital Statistics any question about comparability of statistics compiled and rates under the new vs. the former ICD.

Police Protection On House Calls Promised By Mayor

The December issue of *New York Medicine* featured an article under this headline, detailing the plan of the Police Department to protect doctors in the nation's largest city from death in the streets of New York. Says the order:

"To provide greater security for physicians in answering house calls to administer to the sick and injured . . . the following procedures are effective forthwith:

"a. A physician intending to visit a patient in an area where he believes he may become the victim of a crime, shall dial the Police Emergency Number 911, state the reason for his call and give the location to which he is responding.

"b. The Communications Unit shall direct the nearest available radio motor patrol car to respond to the desired location to meet the physician.

"c. Upon arrival at the scene a member of the radio motor patrol crew shall accompany the doctor on his house call. At the termination of the doctor's visit, the member of the force concerned shall escort the physician to the place of the original contact, notify the Communications Unit that the escort is completed and resume patrol."

So there will be no mistake, the order adds that "The aforementioned procedures shall apply in all boroughs and the escorts provided during the day or night time."

for the problem drinker



Berocca®

TABLETS
high potency B-complex and C
for nutritional support

AVAILABLE ONLY ON Rx

contains water-soluble vitamins only

b.i.d. dosage

good patient acceptance

no odor, and virtually no aftertaste

Each Berocca Tablet contains:

Thiamine mononitrate	15 mg
Riboflavin	15 mg
Pyridoxine HCl	5 mg
Niacinamide	100 mg
Calcium pantothenate	20 mg
Cyanocobalamin	5 mcg
Folic acid	0.5 mg
Ascorbic acid	500 mg

Usual dosage is one tablet b.i.d.

Indications: Nutritional supplementation in conditions in which water-soluble vitamins are required prophylactically or therapeutically.

Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B_{12}.

Dosage: 1 or 2 tablets daily, as indicated by clinical need.

Available: In bottles of 100.

ROCHE

Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Professional Liability Insurance Contracts

J. Jerry Wood, J. D.

Insurance contracts do not hold for the average reader a great deal of interest. Very few individuals bother to read the large print much less the small print of their insurance contracts.

In the case of physicians and their malpractice insurance policies there are certain actions required of the insured by the insurer. Physicians must be well aware of the policy requirements and provisions if they are to be covered in the event professional liability actions are filed against them.

Nearly all policies contain a provision requiring the insured physician to give "timely notice" to his insurance carrier after he becomes aware of any malpractice error or any possibility of a patient suit covered by the policy.

Failure of the physician to give such "timely notice" is generally considered a material breach of the policy which in many cases relieves the insurance company of all liability.

In the case of *Sohn* vs. *U. S. Fidelity and Guarantee Company*, 352 F. 2d. 65, as reported in *The New Physician*, November, 1969, the physician operated on a patient to correct an inguinal hernia. On the following day the patient complained of pain, and a subsequent operation performed by another surgeon revealed that a suture had passed through the edge of the femoral nerve. The first physician admitted that he had caused the injury and cancelled his surgical bill. However, he waited until receiving a letter from the patient's attorney, some five months later, to notify his insurance company. The physician's delay was held to be a material breach of the insurance contract provisions. The timely notice requirement which said that the company must be made aware as soon as practicable after the insured physician knew of the alleged injury had been breached. The U. S. Circuit Court of Appeals held that the doctor should have given notice as soon as he learned of the alleged injury.

In the case of *U. S. F. & G.* vs. *Ditoro*, 206 F., Supp. 528, the patient complained of abdominal pain and his physician called in a surgeon who did an appendectomy with the referring physician assisting him. After complications, the surgeon performed two additional operations. Subsequently, the referring physician received several letters from the patient's attorney, one of which threatened suit and another suggested settlement. The physician gave no notice to his insurer until suit was actually filed against him several months later. The physician claimed in an affidavit that the reasons he failed to give notice sooner were:

1. It was his understanding that the alleged injury was the result of surgical procedures,
2. that he had not performed the surgery,
3. and, that he did not believe his insurance policy covered surgical treatment.

The physician's motion to dismiss the insurance company's suit was denied on a legal technicality. The court did not rule as to whether or not the physician delayed too long in giving notice. Obviously, the physician would have had less difficulty had he given notice to the insurer when the letter threatening suit was received.

In *Bergh* vs. *Canadian Universal Insurance Company* 197 So. 2d. 847, a physician who had performed two operations on the patient with complications after each operation ignored a letter from the patient's attorney asserting a claim against the physician. The physician

waited five months after receiving the letter and five weeks after suit was brought to notify his insurance carrier.

A Florida appellate court affirmed the trial court findings that the physician had failed to give timely notice to the alleged injuries as required by his policy. The court held that such failure constituted a material breach of the policy relieving the insurance company of all liability.

Professional liability insurance is a valuable and necessary asset to the practicing physician. The physician must be familiar and comply with his professional liability insurance contract requirements in order to maintain the protection that the policy affords him. His policy undoubtedly requires him to notify his insurer as soon as he is aware of any medical accident which might conceivably result in a claim against him. As these cases point out to delay in cases like these is not only foolish but may be very, very costly.

Facts About Medicare Eligibility That Affect Your Pocketbook

If you are a Doctor
Or a Hospital Administrator
Or the Administrator of an Extended Care Facility
Or concerned with Part A Home Health Services . . . .

Then you need to know that:

Not all patients 65 and older are eligible for Social Security coverage if they have to go into a hospital or extended care facility, or need Part A home health services.

What Are the Factors That Determine Eligibility for Coverage?

1. Age. If the patient reached age 65 BEFORE January 1, 1968, he is automatically entitled to medicare coverage by Social Security because of the transition period that was written into the law.

   BUT, if he reached age 65 ON OR AFTER January 1, 1968, in order for him to be covered he must have worked under Social Security or must be a Social Security beneficiary, or must be eligible to be a Social Security beneficiary.

2. Social Security beneficiary

   (a) Any person who draws a monthly Social Security check is a Social Security beneficiary. This includes wives who have never worked but who are eligible because of husband's eligibility, or vice versa.)

   (b) Persons who are still working after age 65 but who would be eligible for Social Security payments if not working. (A person must file for Social Security payments.)

3. Quarters of coverage required

   In order to be eligible for medicare benefits for hospital and post-hospital coverage (see paragraph 2, item 1, above) a person OTHER THAN A SOCIAL SECURITY BENEFICIARY must have had so many quarters of coverage, as outlined in the chart below:

Year that Age 65 was reached	Number of Quarters of Coverage Required
Before 1968	0 (Transition period)
1968	3 (Whenever acquired)
1969	6 (Whenever acquired)
1970	9 (Whenever acquired)
1971	12 (Whenever acquired)
1972	15 (Whenever acquired)
1973	18 (Whenever acquired)
1974	21 (Whenever acquired)

Supplementary Medical Insurance coverage is available to any person age 65 or over who pays the monthly fee (now $4.00 per month).


Each 5 cc. contain erythromycin estolate equivalent to 250 mg. erythromycin base.
PINT (473 cc.) M-148
Lilly
ILOSONE® LIQUID
ERYTHROMYCIN ESTOLATE ORAL SUSPENSION, U.S.P.
125
SHAKE WELL BEFORE USING
AVOID FREEZING
PINT (473 cc.) M-153
ILOSONE® LIQUID
ERYTHROMYCIN ESTOLATE ORAL SUSPENSION, U.S.P.
250
When mixed as directed, each 5 cc. will contain erythromycin estolate equivalent to 125 mg. erythromycin base.
When mixed as directed, each cc. will contain erythromycin estolate equivalent to 100 mg. erythromycin base.
Each 5 cc. contain erythromycin estolate equivalent to 125 mg. erythromycin base.
50 TABLETS No. 1834
ILOSONE® CHEWABLE
ERYTHROMYCIN ESTOLATE TABLETS, N.F.
125 mg.
Each tablet contains erythromycin estolate equivalent to 125 mg. erythromycin base.
100 PULVULES® No. 375
ILOSONE®
ERYTHROMYCIN ESTOLATE CAPSULES, N.F.
250 mg.
100 PULVULES® No. 374
ILOSONE®
ERYTHROMYCIN ESTOLATE CAPSULES, N.F.
125 mg.
Each Pulvule® contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule contains erythromycin estolate equivalent to 250 mg. erythromycin base.
The many forms of Ilosone®
Erythromycin Estolate
Lilly
Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206
900761

THE JOURNAL

of

THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

Published Under the Auspices of the Board of Censors

Volume 39 **January, 1970** **Number 7**

Immunologic Psychology And Psychiatry*

Wallace Marshall, M. D.

Montgomery, Alabama

It has been wisely stated that an individual can avoid growing old by keeping an open mind for new data which should be sought with avidity, for today's so-called truths may become old wives' tales because of additional or future data. It is facile to employ those formulae which one has mastered previously because this is much easier on one's nervous system to avoid the necessity of having to relearn a new concept or procedure or revise one's beliefs he has cherished for years. However, the perpetually intellectually young person goes through life with concepts which have not become stultified by rigidity with one's cerebration.

The Parable of the Gum Ball Machine

Once upon a time three very learned psychologists decided they would enjoy some chewing gum. They spotted a gum ball machine down the corridor of their building. One of them followed the directions on the machine and dutifully deposited his penny in the coin slot. Almost instantaneously, a beautiful red ball of gum rolled into the receptacle. Another of the group then deposited his penny in the machine's slot, and out came a beautiful yellow ball of gum. Then the last group member deposited his coin. He waited and waited for his gum ball with keen anticipation, but, alas! nothing happened.

They began discussing the situation, at first calmly, then most vociferously. Then they pounded on the machine and finally kicked it. Still no gum appeared. They began to swear as they shook the machine with all of their might as they shouted four letter words. Just then, a kindly man appeared who seemed to understand their plight. Carefully but swiftly and skillfully, he disassembled the machine. He smiled as he returned their penny. Then, as he left them and walked down the hall he was heard to softly whistle "I can't give you anything but love, baby." A dog in a nearby room happened to overhear the conversation as he was running a maze. He stopped, thought for a while, then yapped "yep!"

What this fable underlines is the real importance of knowing the mechanics of the machine or the way in which it functions besides the stimulus-response aspects of behavior. Something went wrong so that the expected stimulus-response behavior of the

* Presented to the graduate students and faculty in Psychology at Auburn University, November 19, 1969.

machine was not present. Similarly, it is important to study the stimulus-response in individuals, but perhaps it is just as important, or even more so, to understand the inner mechanisms which may be involved with stimulus-response mechanisms with each living organism. This is the reason for studying the *modus operandi* which have to do with biologic behavior. As the terms imply, immunologic psychology and psychiatry use some of those principles found in the study of immunology to explain such important events as learning, and normal and abnormal behavior. The individual becomes aware of the changing environment by means of his five afferent neural pathways which produce electro-chemical imprinting in his recipient cerebral cells. This is essentially a process of learning. But those powers of cerebration (thinking) include sensory perception, cerebral imprinting or encoding and the storage of such information and its retrieval (remembering or recall) upon one's volition.

We consider these afferent neural stimulations to the cortical centers as being psychoallergens, or psychoimmunogens, if you prefer the latter term. Such perceptions and those changes these produce seem to be related proportionally to the nature, the size or caliber of the dose, how long these afferent stimuli operate, and most important, whether or not previous related neural stimuli have affected these same cortical cells. In other words, we are extending the conditioned reflex response to include the exact nature of the induced stimulus or stimuli and their effects upon the brain encoding areas.

The above aspects of our immunologic theory have been published in a series of four papers [1, 2, 3, 4]. I trust you have had ample opportunities to have studied this different biologic approach to behavior.

The importance of the size or caliber of various psychoallergens has been stressed. As an example, viewing television in black and white surely is not as striking as seeing similar scenes in vivid colors.

To further elucidate this particular point, let us assume we fire a revolver on an empty cartridge chamber. Only a clicking sound will ensue. But then we fire the weapon's cylinder which contains a blank cartridge. The difference in effect may well be overwhelming, for some onlookers may cringe and scream when the revolver is fired. This may not happen when the empty cylinder of the chamber is fired. In other words, the size or dosage of the psychoallergen (the revolver's noise in this case) will markedly imprint the incoming sensory stimuli (sight and sound) on the recipient cortical cells. We can predict that the observers of the experiment will remember this experiment for a long time. We assume that the marked imprinting process in the recipient cortical cells has produced more of a electrochemical change which will favor a stronger memory retention than would result from the firing of the empty revolver chamber with its harmless clicking sound.

Let us assume that when the revolver discharged with the blank cartridge that a bystander fell over as if wounded. The impact from such a scene could well lead to pandemonium. Not alone did the revolver's noise imprint the recipient cortical cells through the auditory pathways, but also the optic tracts would reinforce the afferent effects from such an experiment. Witnessing a supposedly wounded individual who was supposedly shot would make the effects from such an experiment much more vivid as one might imagine.

Allow me to tell you about two former patients. One was a young mother, who was backing her car down her driveway, when she felt the car bump as it ran over something. She immediately stopped her car and ran back to find her two year old daughter sprawled motionless on the ground. The up-

shot of this true event was that the child spent six weeks in the hospital but made an excellent recovery. But in the meantime, the mother developed a severe psychosis and had to be admitted to a mental hospital. She improved somewhat with therapy, but about two years later, she committed suicide because of her continued depression.

Obviously, the sensitizing dose of psychoallergen for this parent, upon hearing and seeing this horrible accident, overwhelmed her so that she never fully recovered from its traumatizing effects on the encoding brain centers.

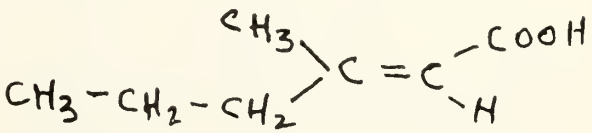
The other individual was a brilliant doctor of medicine. He was returning home with his wife in his car. As he approached a railroad crossing he did not see or hear the oncoming locomotive. He wife was killed outright, although he escaped miraculously and unscathed.

From that time on, he avoided this railroad crossing by always driving many blocks out of his way, because he wished to avoid reintroducing those associated psychoallergens (seeing this particular railroad crossing) which he found to be so painful that it would prove unbearable.

It wasn't long before he moved to the Pacific coast in order to permanently avoid these painful memories. In this case, the doctor became almost immediately hypersensitized to those psychoallergens which produced such an untoward reaction. His escape from the possibility of having to deal with seeing this railroad crossing was most understandable. Moving his home from this painfully sensitizing scene was, in reality, a rest cure from further sensitizations which occurred every time he saw this railroad crossing.

We may now realize that such traumatizing situations (environmental) are stimulus-specific. Each has its own inherent aspects. Hypersensitization of one's recipient cortical cells can occur almost immediately if the dosage of psychoallergens happens to be overwhelming. The resultant electroneurochemical cortical cell changes should be similarly extensive, so that memory retention in such events should surely be long lasting if not life-long, unless therapeutic desensitizations are employed to lessen such effects. Desensitizations may take the form of psychoanalysis, behavioristically orientated conditioned responses with relearning, by the use of certain therapeutic drugs, hypnotic suggestion and with other therapeutic modalities such as the time-honored rest cure.

About a month ago, Smith, Thompson and Koster[5] identified an odorous substance in the sweat of schizophrenics which was not found in normal individuals. The compound is called trans-2-methyl-2-hexenoic acid.



This discovery lends additional credence for a biologic approach to the psychoses.

Had researchers limited themselves to merely studying the behavior (external aspects) of schizophrenics, they never would have found this aberrent material in schizophrenics. This fact is important because it stresses the need for knowledge from the basic sciences, and it emphasizes the importance of learning what takes place in the brain to cause such a pathologic chemical reaction.

Since this substance was found in schizophrenic sweat, we can speculate that some pathochemical reactions ensued with these hypersensitized cortical cells. The material entered the venous return from the brain and it was carried in the blood stream to the skin. We know that water balance and the body's thermal (temperature) control are connected intimately with the physiology of the integument (skin). This water loss in the form of sweat allows for the identification of this odorous substance in schizophrenic patients but not in normal

humans. This may well be a primary step towards the discovery of the pathologic process in this important malady.

Let us define some terms which have been used so far. *Immunology* is the study of the biologic aspects which have to do with immunity, which an individual has or might obtain to render himself harmless to diseases, poisons, or infections or to other harmful influences or agents. An *immunogen* can produce a specific antibody against such a noxious agent or substance. This is a form of immunity. An *antigen* is a material which is able to specifically react with an antibody, or in certain circumstances can produce an antibody. An *allergy* is a form of disease where a specific sensitivity becomes increased to an allergen or a hapten. Allergies are often produced by delayed states of sensitivity from contact allergens or the immediate forms of sensitivities because of Prausnitz-Kustner antibodies. So we can note that the term immunology seems to be more encompassing than that of allergy. For this reason, Psychoallergy should be changed to Psychoimmunology to be more explicit.

Immunity is related to the individual's ability to overcome or to resist infection. It was produced by some form of trauma, since infection can harm the individual. Immunity protects the body from such injury. So an immune individual is free from such a threat to its welfare or well-being.

Dorland[6] defines psychiatry as "that branch of medicine which deals with disorders of the psyche." Psyche is defined as "the human faculty for thought, judgement and emotion; the mental life, including both conscious and unconscious processes."

Perhaps we can define psychiatry as the study of brain physiology and its pathology which may lead to aberrent behavior, which may be produced by psychoimmunologic hypersensitizations which can produce neuroses and psychoses. It includes the processes of learning, which if affected, might produce such disorders as the amentias and dyslexias, although some disorders of cerebration may be caused by the anoxias, arteriosclerosis, etc. due to nerve or brain traumas.

From a biologic viewpoint, psychiatry can be considered as the study of the individual's reaction to nerve and brain injury which affects the *sensitivity* of the involved tissues.

We realize that excessive stimuli which originate from one's environment can injure the individual. Excessive heat can raise a blister on the finger of a cook. This is a form of the person's reaction to injury. The surgeon can remove his patient's kidney. This produces trauma. But the patient's body can react to this injury by doubling the size of the patient's remaining kidney. This is a form of compensation, since now the remaining and enlarged kidney takes over the function of the extirpated kidney with its own functions, and the patient then can survive this surgical injury.

Injury is defined as damage inflicted to the body by an external force or stimuli of any type. Also, excessive environmental stimuli can produce bodily injury. As an example, excessive and constant noise can produce the loss of hearing. Or the excessive, blinding light from a ultraviolet machine can cause very painful blindness in one who becomes so exposed to such excessive visual stimuli. Such a situation affected me about six hours after I had irradiated a batch of chemicals without the protection of colored goggles. I began to notice rings which appeared around lights, then the presence of terrific pain in the eyes. Soon I became completely blind. I called my wife who summoned an ophthalmologist who relieved this malady with the use of proper eye drops.

How can visual and/or auditory hypersensitizations occur psychologically? Any student who wishes to find the answer can ask his teacher a question and then repeat this procedure often enough so that signs of hostility begin to become evident in the teacher's behavior. Some sort of overt action

will ensue if such a procedure is repeated often enough. This will depend upon the caliber of electroneurochemical changes which such sensitizing or encoding processes have produced in the teacher's receptor brain cells.

The time element in sensitizing cortical reactions is of major importance. If I space my phone calls properly to my editor, he might not object to them. But if I shower him with these phone calls, his reactions might not be able to appear in print. Should someone mention my name shortly after such an unhappy event, he may well "hit the ceiling" with his obvious annoyance and hostility. He will have become hypersensitized to the excessive perceptual stimuli which I showered upon his receptive cortical centers. His hostility ensued because of the Leyden jar discharge or surmenage which was produced by his cortical oversensitivity or overlearning.

Recently, my wife and I were being shown a new university campus by the wife of a faculty member who was driving the car. Suddenly, another driver apparently lost control of his car which struck two other cars and then headed in our direction. Luckily, he stopped his automobile before it rammed into the rear section of the car we were in.

Our friend became visibly pale, nauseated and nearly averted shock as she barely was able to park the car in an adjacent filling station driveway. She was unable to talk for some time and bent over the steering wheel. But slowly she regained her posture and overcame her near shock. She had related that she nearly lost her life in a recent auto collision, and only a few days ago had been in another less serious auto accident.

This case demonstrated the two episodes of serious hypersensitizations her cerebral centers suffered from what she had seen, heard and had felt as the results from these accidents. Then the current strong input of sensory reactions ensued when she saw the oncoming car as we sat in her automobile. These maximum sensory excitations met recognition within her encoding cerebral centers. A Leyden jar-like surmenage from these seriously hypersensitized cortical cells ensued, were transmitted to the motor and autonomic nerve tract outlets, and she reacted as has been described.

My wife and I were not too "shaken up" by this near accident because we had not been hypersensitized by such a tremendous influx (hyperdose) of psychoallergens as was experienced by our friend. In other words, hyperlearning from the marked influx of previous related psychoallergens had not taken place to produce such encoding in our perceptual cortical centers, but this did occur with our hostess.

Wilhelm Steckel's famous case comes to mind. A patient consulted this psychiatrist because he was unable to have coitus unless his sexual partner wore boots. Steckel discovered the reason for his patient's difficulty from an experience the patient had, when his governess seduced him during adolescence. She happened to wear boots at that time. He had become hypersensitized to what he saw and heard during the episode. The fact that his governess was wearing boots became an integral part of his cortical hypersensitization.

These examples of hypersensitizations connected with cortical learning or encoding do not appear to be explained readily on a simple Pavlovian S—R conditioned response. As has already been stressed, the nature and size, plus the time a stimulus operates, seems all important, plus whether or not previous associated stimuli have affected the cerebral recording centers. At this time we are interested mainly in the afferent or the receiving aspects of such behavioral reactions. The ensuing efferent aspects of behavior, such as the motor or the autonomic manifestations, which result usually in muscle action, are greatly dependent upon the previous encoding processes in the brain.

This afferent portion of so-called conditioning is usually programmed by such learning processes (brain encoding) which can be based upon what is considered to be normal brain sensitizing reactions. If these are excessive, then hypersensitizations take place which may lead to pathologic cerebral states.

Phobias and Manias

Environmental stimuli can be either pleasant or painful. For example, if one strokes or pets a canine, such stimulations are usually pleasant. The dog responds by wagging his tail and licking the hand of the person who is doing the petting or by showing a scratch reflex. But if the caliber of the petting or stroking of the dog's skin becomes excessive, the sensation of pain occurs in the dog who may growl, snarl, or even snap at his tormentor.

Similarly, if afferent stimuli are mild but stimulating, as exemplified by hearing the music played by a symphony orchestra, such incoming stimuli set up pleasing cerebral reactions. But if this same orchestra's percussion section goes wild and hammers vigorously on their gongs, tympani, kettle and bass drums, and blows their whistles, this may generate excessive aural stimuli which may cause the audience to shut off such cacophonic stimuli by putting their hands over their ears and also voicing their disapproval by their screams, cat calls, and boos, or heading for the nearest exit.

Furthermore, if cerebral encoding continues for protracted periods, there may be a probability that certain types of neuroses may be generated. Possibly the type of neurosis might be predicated upon whether or not such cerebral hypersensitizations were either painful or non-painful. A review of such case histories may indicate that *manic* reactions were caused by excessive *non-painful* hypersensitizations, while *painful* hypersensitizations may produce *phobic reactions.*

A kleptomaniac enjoys shop lifting, because such is based upon *pleasant* hypersensitizations. A phobic child becomes so affected because of painful hypersensitizations. Here is a case in point. While playing in the school yard, another young boy removed a garter snake from his coat pocket. He began to whirl the serpent by its tail around and around his head. Finally, the snake's head became detached and it happened to strike our young patient on his face. He was splattered with blood from the snake. Since this incident which occurred during his early grammar school days, he has become markedly afraid of snakes. In other words, he has continued his phobic reactions which were produced originally by his painful sensitizing period.

Pavlovian Concepts

Ivan Petrovich Pavlov (1848-1936) studied the conditioned reflex in dogs, apes, and by observations with mental patients. He termed his approach "the science of higher nervous activity." His research on the physiology of digestion soon showed that this and all organ functions were under the influence of the nervous system. This concept he called "nervism." But soon he found that psychic stimulation was involved, because when his animals saw the individuals who fed them, or when they smelled their food, salivation took place. At first he felt that psychologists should pursue this study, but he agreed finally to study such psychic behavior. One of his laboratory colleagues resigned because he felt that such studies were contrary to his religious beliefs, because the human mind and soul should not be tampered with.

Pavlov separated these reflexes into conditioned and unconditioned types. He believed that the unconditioned type was identical to instincts. He thought that conditioned reflexes were highly important to the individual's basic or minimal survival. He regarded the unconditioned reflexes as including nutrition, reproduction, orientation

and defense. Their mechanisms, he believed, were confined to the subcortical brain areas.

He held to the view that conditioned reflexes helped the individual to adjust to his constantly changing environment. This mechanism was located within the cerebral cortex. He believed that its functions were produced by either excitation or inhibition. He believed the latter induced sleep and hypnosis, since in these cases inhibition checked excitation. Pavlov's theory for mental disorders was that the clashing of stimuli in the cortical brain areas overtaxed them. He advocated rest as a form of therapy. You may recall that Wier-Mitchell professed a similar idea as to therapy. Both investigators used such prolonged sleep periods which might last for weeks.

Pavlov was the first who produced laboratory breakdowns in his animals. He termed this phenomena "experimental neurosis." The milder forms he found amenable to therapy. He believed that higher animals had two operational systems:

1. The unconditioned reflexes system. 2. The sensory conditioned system which he also termed the 1st signalling system. He taught that humans have these 2 systems plus a third, the 2nd signalling system which allows man to use grammar plus a vocabulary (symbols). Thus humans can think, form concepts and make use of their experiences. But of utmost importance, man can think before he acts.

Pavlov claimed the breakdown of these three major systems in mental disease. Hence, cortical control becomes lost and the ensuing behavior operates without cortical guidance. Pavlov was very interested in learning the pathophysiology which produced abnormal behavioral reactions. Freud harbored an identical wish. However, this only began to show fruition with the advent of the neurosciences. This research began in interest only about ten years ago.

We owe much to these and other genii who paved the way for scientific studies of behavior. Furthermore, they accomplished so much with a paucity of experimental armamentaria which was available for their researches.

Then came Watson, Hull, Skinner and other greats who followed this behavioral work. But they did not evolve theories which explained their behavioral concepts in biologic terms. Each group had its own terminology to explain what they observed. Even the Freudianists evolved such complex terminology that members of that school experienced difficulty in understanding one another. During this long interim, the biologically oriented workers objected to these many terms which were not meaningful for them, so that a Tower of Babel became highly evident among the various scientists who had to do with cerebration and behavior.

> "Go to, let us go down, and there compound their language, that they may not understand one another's speech."
>
> —The Tower of Babel
>
> from Genesis 11, Old Testament

Need for a reliable theory of behavior

Schwab and McGinnis[7] wrote about the need for a general theory to underpin psychosomatic work. Numerous investigators have voiced a similar viewpoint. Engel[7] remarked about "the lack of any such general theory which is based upon well documented facts which keeps our field fragmented and divided." Schwab and McGinnis suggested that, in the absence of such a general theory, they might use assumptions to find valid premises which might serve as a springboard for further efforts at theory formulations.

This is my raison-e'etre for presenting the theory of psychoallergy or psychoimmunology. Possessing a biologically oriented background, this approach is presented in biologic terms which are devoid of psycho-

dynamic and Freudian nomenclatures. It is hoped that all future investigators who deal with cerebration and behavior will at least secure a working knowledge in all the basic sciences. Such an approach should assist markedly in overcoming our current Tower of Babel situation and assist in uniting psychology with biology as closely related sciences.

Allow me to mention, in a facetious manner, my proposed law of dissent. The degree or amplitude of complaints against a theory may be directly proportional to its intrinsic value. Perhaps you might discover this realism if you will recall the violent attacks which took place when Semmelweis blamed the unwashed hands of those doctors who delivered women. The cause for childbed fever (puerperal fever) was discovered because of his assertions. His antagonists called him a mad Jew and drove him to insanity. Such appears to be par for the course with most new ideas, because very few individuals like to be informed they are in error and should study these newer approaches.

In the time remaining, let us consider rapidly a few important psychologic topics from a psychoimmunologic viewpoint.

What causes dreams?

We may postulate that dreams result from random Leyden-jar like discharges of potentials from a particular cortical area as the result of sensitizations. Whenever the "never-never land" or the "twilight zone", also known as the "latent" or the "set" period, becomes dominant, cortical discharges of potential are shunted to the thalamic areas where awareness occurs during such a dreamy state. A recent cortical sensitization might be the cause for a dream in many instances due to recent unusual environmental stimuli which sensitize the individual. Recurring, violent dreams or nightmares may be due to such discharges from hypersensitized cortical areas.

What about Hypnosis?

Whereas dreams may be produced by cerebral sensitizations and hypersensitizations, hypnosis presents a different picture. Although "set" or "latent" periods are necessary for dreams or hypnosis to take place, the discharge of potential from the cortex triggers dreams. It is essentially an *efferent* response. But with hypnosis, in the presence of "set" or "the latent period," the hypnotist's psychoallergens gain admission to the brain's recording centers free of extraneous interference. This can be considered as a type of direct learning without autogenous or heterogenous interferences which can impede the encoding process. So the production of hypnosis is essentially an *afferent* process.

Both dreams and hypnosis may involve the Papez circuit, referred to by Mackay[8] in his discussion of affect and the functioning of the hippocampal and mamillary areas of the brain.

Perhaps one of the finest recent discussions of hypnosis comes from Kraines[9], who mentions that so-called sleep can be induced by varied forms of inhibition. During such a state, dogs would stand motionless as if carved of wood. This directly involves the latent period. Following Pavlovian concepts, Kraines points out that isolated or continuous stimulation of a definite area of the cerebral hemisphere leads to sleep or drowsiness. This may well produce a form of cortical cell sensitivity or even of hypersensitivity. This Pavlovian inhibition of the cerebral cortex may be associated intimately with set or the latent period as we have mentioned. It appears that our theory is really an extension of Pavlovian principles, because those psychoallergens or psychoimmunogens which encode the cerebral cortex may produce the above states. I urge you to carefully read Kraines' article and compare these Pavlovian principles with those of our theory. If it proves to be worthwhile, it should prognosticate behavior as any other reliable theory should do. Although its

tenets are rather simple and uninvolved, this property should make it more preferable to more involved theories. It has so many correlations which seem to reinforce its value as a working theory. With it, we should recognize the effects of afferent energy (imprinting) on the cerebral cortex and its efferent discharges of potentials. The caliber of such surmenages of potential will determine the efferent responses which, in turn, activate autonomic or motor behavior.

References

1. Marshall, W.: Learning and the development of frustrations. J. Med. Assoc. St. Ala. 38:622, 1969.

2. _____: Theory, learning and origin of complexes. J. Med. Assoc. St. Ala. 38:916, 1969.

3. _____: Normal and abnormal behavior from learning. J. Med. Assoc. St. Ala. 39:40, 1969.

4. _____ Immunologic augmentations for learning and psychiatry. J. Med. Assoc. St. Ala. 39:243, 1969.

5. Smith, K., Thompson, G. F. and Koster, H. D.: Sweat in schizophrenics: identification of odorous substance Science, Oct. 17, 1969, p. 398.

6. Dorland's Illustrated Medical Dictionary, W. B. Saunders Co., Phila., 24th Ed., 1965, p. 1243.

7. Engel, quoted by Schwab, J. and McGinnis, N.: Toward a concept of comprehensive medicine. Psychosomatics 10:69 (Mar.-Apr.), 1969.

8. Mackay, R. P. in Recent Advances in Biologic Psychiatry, Ed. by J. Wortis, Grune and Stratton, N. Y. 1960, p. 7.

9. Kraines, S. H.: Hypnosis: physiologic inhibition and excitation. Behav. Neurophysiol. 1:11 (Sept.) 1969.

Pulmonary Function Testing For The General Hospital and Physician

D. S. Tysinger, Jr., M. D.

Dothan, Alabama

Part II—Abnormal Physiology

In Part One normal physiology was briefly reviewed as it related to function. In so doing, discussed were four basic forces and one resulting negative state that had to do with physiology and the function of the lung. This section will consider abnormal physiology of these various states, as well as the other elements of normal physiology which were discussed.

The first force discussed was Force A. This was the force of the chest cage and diaphragm. If the movement of these two are stopped completely, as is seen in bulbar polio and some of the other paralytic diseases, then death insues rapidly. Breathing is absolutely dependent on the movement of the diaphragm or chest cage or both. Other than complete paralysis there are injuries such as breaking of ribs (multiple, so-called "flail chest") in which the chest cage is unstable. This causes the chest cage to collapse inward and then go back to normal position as breathing efforts are attempted with no real exchange of air in and out of the lungs. In conditions such as this the chest cage must be fixed so that the mechanical effectiveness of breathing is maintained or so that it can be maintained with mechanical ventilation. A second common derangement of the forces is that of stooped shoulder, bending and freezing of the spine, as seen in dorsal kyphosis or kyphoscoliosis, in which the relation of the spine and ribs to the chest cage diameter becomes fixed and only muscle contractions and ribs distortion now are active for the rib cage as an A force. Paralytic diaphragms or a paralytic leaf or two will allow the diaphragm to move opposite from the way it should. Finally, there is the so-called "funnel chest" in which the chest shows a marked concavity. All of these are A factor diseases. Also included in this group of diseases can be the pleural fibrotic processes which form thick membranes that allow little effective movement of the chest cage, such as organized empyema, etc. All of these restrict the ability of the chest cage to expand and also restrict the ability of the chest cage to collapse. In so doing these reduce the volume of air that can be exchanged by the lungs. Assuming that all other components of the lungs are normal, then the big difficulty with these conditions are those of restriction of total volume and A factor diseases are spoken of as restrictive diseases.

Next are the B factor diseases. It should be pointed out at this time, as a rule, one finds B, C, and D factor diseases—as well as many of the E factor diseases—all as a greater or lesser degree of the same process; rarely as isolated instances. First, in the B factor diseases would be included those diseases and conditions which cause fibrotic changes in the alveolar wall and that cause a loss of effective surfactant support of ventilation in the alveolus. These restrict the ability of the alveolus to get larger and smaller and these conditions are also primarily restrictive in nature. As the alveolar membrane thickens from any cause there is also a disturbance in the ability to get oxygen into the blood stream. At the same

This is the second in a series of seven articles.

time there is little or no difficulty in getting carbon dioxide from the blood stream into the alveolus. Also, with an alveolus of this type in which the change of size is very slight, there is also increased difficulty in exchanging the air within the alveolus itself. Therefore, carbon dioxide tension in these alveoli tends to increase and as it does, arterial oxygen saturation decreases. As this occurs, there is further decrease in the ability of the partial pressure of oxygen now existing in the alveolus to push oxygen through to the pulmonary capillary bed. In most instances where there is such an effect in the alveoli there are usually sclerotic or fibrosing changes which obliterate arterioles and capillary bed also. With these changes there are extreme chest cage efforts to produce ventilation; thus, greater negative interstitial pressure is produced with an increased blood flow by these poorly ventilated and restricted alveoli. This causes increased PCO_2 and disproportionately low oxygen saturations. If this is a generalized disease pattern then one would expect high carbon dioxide levels, low arterial oxygen saturations, and poor interpulmonary mixing primarily at the alveolar level. A second form of B factor disease is that commonly seen in emphysema in which the alveolar area breaks down into large irregular air sacs with loss of elasticity and usually with loss of the surfactant lining material with the resultant loss of the normal collapsing force that is usually present at B. There may be interference with oxygen transport. With this type of alveolus there is little or no contracting force against Force A to make interstitial pressures at E negative. Therefore, when the A force starts developing on inspiration, there is not the usual negative pressure and thus there is a reduction in circulation by this alveolus. As previously mentioned, as the small alveoli degenerate into one confluent emphysematous sac, there is a general and marked loss of vascular bed so that there is not only a less negative vascular bed area which tends to retard the flow of blood, but the vascular bed itself is markedly reduced. In order to maintain blood flow the right heart has to increase its pressure to keep sufficient quantities of blood going past this capillary bed area. On expiration, the same problem still exists; the normal elastic collapsing force is not present. Therefore, the chest cage (Force A) now has to contract and actively push the air back out of the alveolus. In this situation the remaining pulmonary capillary bed is now put under positive pressure which markedly retards the flow of blood past this area and which, again, causes an increase in right heart pressure to maintain circulation. If this is a generalized disease, then it is easy to see that arterial oxygen saturations may be, and usually are, normal due to the disproportionately low capillary bed to the large emphysematous spaces. CO_2 exchange is, as a rule, not a problem. In addition to the loss of elasticity and poor ventilating ability there is then a rather marked strain put on the right heart by the decreased pulmonary capillary bed with an increase in positive pressure now having to be developed in order to circulate blood past these emphysematous capillary areas. As this is occurring, the primary expanding and collapsing force is dependent upon the muscular effort of the chest wall, diaphragm, and abdominal wall. The movement is slower and a greater muscular effort is necessary for ventilation. Another form of B factor disease is that related to high pulmonary capillary pressures or low circulating blood osmotic pressures. In disease of the left heart which causes the heart not to completely empty, there is at the end of each beat, blood remaining in the heart with increased pressure. This becomes reflected into the left atrium where it then continues through the pulmonary venous system into the pulmonary capillary bed. This back pressure is hydrostatic pressure and, as back pressure occurs and increases, there is a disproportionate increase in pulmonary arteriolar vasoconstriction with a disproportionate increase in pulmonary artery pressure. As this develops the hydro-

static pressure at both the arterial and venous end of the capillary bed is such that osmotic pressure and tissue pressure are overcome and fluid remains outside the vascular system. As the heart continues to beat, more and more fluid is distributed outside of the vascular system. The lymphatics begin to be incompetent and an inability to handle the increase in fluid exudate develops and is known as interstitial edema; increased fluid in the interstitial tissues. If this continues this fluid then overflows into the alveolus. If the pressure rises rapidly then exudation can continue. This protenaceous material which is excreted begins to fill the alveoli and then the bronchial tubes with bubbly, foamy mucous material and the state of acute pulmonary edema has developed. As the fluid begins to collect outside the capillary and in the interstitial tissue but not yet in the alveolus, carbon dioxide is in no way interfered with and continues to equalize with the alveolus without any difficulty. However, due to the solubility of oxygen in fluid being very low and since it must be physically dissolved to be transferred to the pulmonary capillary bed, there is now a block to oxygen absorption and so oxygen saturation in the arterial blood begins to fall and get worse as the process continues. The same can happen in situations in which the hydrostatic pressures are normal but in which the electrolytes are low and/or the proteins are low. Thus, the osmotic pressure of the blood drops to such a point that it is not sufficient to cause a reabsorption at the venous capillary end of the pulmonary capillary bed. Also, there are certain infections such as pneumoccal pneumonia which occur in the alveolar area and cause the alveoli to be filled with fluid. Inflammation of the interstitial tissue occurs which interferes with all transport including oxygen and carbon dioxide, and which frequently will compromise the circulation of this area. Next, there would be those B factor diseases which would cause fibrosis of the area as a unit. This would include the terminal bronchioles, the alveoli, the interstitial tissues, and would effectively eliminate the mass of such tissues in equal parts. This type of disease, in essence, reduces the effective amount of lung volume. It is also restrictive in nature.

Next would be those diseases that affect bronchial tubes; these would be the C factor diseases. The C factor diseases can also be of many types. First, would be those diseases that cause fairly solid fibrosis of the tube itself so that it can neither elongate nor dilate; nor can it contract and get smaller. This type of disease is one which is restrictive in nature. Normally, the bronchial tubes would be getting larger and longer in breathing. In this situation they are staying the same size and there is a restriction to the flow of air that can go through these tubes, thus acting as a D factor disease. More air is passing through the same size tube and it must go faster for the alveolar area to get air. The alveoli are somewhat more dilated. Factor A puts forth more effort and in this type of situation a greater negative pressure is produced in the alveolus which now gives a greater pressure difference. Since a greater negative pressure is produced and must be produced in the same time if normal breathing rate is to continue, then the rate of change of pressure must be greater and turbulence is the result. For every tube there is a flow rate for any gas which will cause so much turbulence due to frictional resistance in the gas that the turbulence of the gas itself will completely obstruct the tube. (Factors involved are tube length and diameter, gas viscosity, rate of flow determined by pressure difference at each end of the tube and the rate at which these pressures are developed.) No matter what the breathing effort, if it goes beyond this point, turbulence cannot be overcome and this tube is obstructed. This tube will stay the same size so that, on expiration, greater positive pressures are developed in an attempt to get the air out than was produced in an

effort to get the air in. This produces turbulence on expiration. In this type of disease there is equal difficulty on inspiration and expiration. Since there are greater positive pressures developed on expiration than there are negative pressures on inspiration, then it is understandable that there will be a wide fluctuation of blood flow in and out of the pulmonary capillary bed due to the high pressures developed. This is usually carried over into the peripheral pulse where the volume on inspiration drops markedly and the volume on expiration rises rapidly. It should be pointed out that the diseases of the bronchial tube, or C factor diseases, in one way or another all reduce the size of the bronchial tubes, either locally or generally. Any time the size is reduced there is a reduction of air flow to the alveolus. As a result, greater efforts and greater negative pressures are developed during inspiration in an effort to overcome the obstruction. This, as a rule, further increases the effort. With the exception of the disease just discussed, the tubes do get larger in diameter and longer on inspiration and shorter and smaller in diameter on expiration. Therefore, in the remainder of the diseases of the bronchial tubes, it is easier to get air in with negative pressures more negative than normal than it is to get air out by increasing positive pressure on expiration. The diseases that usually occur here are those of bronchospasm, infection with swelling, edema of the peribronchial membrane, secretions (particularly mucous which becomes thick, inspissiated and plugs the airways), and ulceration of the mucous membrane due to infections with formation of the material over the denuded area with obstruction, etc. There are any number of conditions which tend to reduce the elasticity to a certain extent and which do reduce the diameter of the tubes, either locally or generally. Therefore, the C factor diseases cause an obstruction to air flow and may allow essentially normal amounts of air to be exchanged in and out of the lung but require much greater forces to do so and frequently much longer times to get the same volume of air in and out. Where there is localized disease in the bronchus, then air may pass into the alveolar area on inspiration because of the size of the bronchus becoming greater in length and diameter. As expiration occurs and greater positive pressures are developed to collapse this lung past these obstructions, then the tube rapidly reduces in size and the plug that was easily passed on inspiration now completely obstructs the bronchus and the pressure beyond this obstruction (since pressure falls in this part of the bronchus between the obstruction and the mouth) now collapses the bronchus due to the interpleural pressure and the air is trapped in the alveolus. Since this trapped air remains in the lung at the end of expiration, there is a disparity between the inspired air and the smaller volume of expired air; therefore, in obstructive disease we have another pattern wherein great pressures are developed and in which changes cannot occur as rapidly as desirable due to the smaller tube diameter, turbulence, and resistance to air flow and with bronchiolar collapse secondary to plugs and trapping of air on expiration.

In discussing C factor diseases we have already discussed D factor disease which is turbulence that is produced by resistance to air flow as the rate of air flow is increased. In addition to the obstructive diseases, D factor diseases can be purely mechanical such as in the use of breathing equipment where high pressures are applied at the mouth along with high flow rates in an effort to ventilate the alveoli through normal or through obstructive bronchial tubes. In comparing D factor and C factor diseases, most obstructive conditions can be improved and ventilation increased by slowing the rate at which pressure changes between the mouth and the alveolus are produced to the point that tube size and flow rates are now compatible and turbulence is not developed. When one uses breathing

equipment it is necessary to control very accurately the flow rate and the rate of pressure change, particularly where obstructive disease is being treated, since the individual is having difficulty already at the flow rates he is developing without the increase in pressure of the respirator. In such C factor diseases as asthmatic bronchitis, for example, an individual can frequently be made quite comfortable if one can get him to breathe slow enough and deep enough to lower flow rates through the bronchial tubes thus stopping the turbulent obstruction of the airways. The usual feeling of the patient with obstructive disease is to attempt to breathe deeper and faster at high inspiratory levels to utilize larger tube diameters. As a rule the rate is so fast and the pressure difference is built up so quickly that the flow rates are too great, turbulence ensues, and ventilation is markedly decreased. This can only be corrected by slowing the rate at which pressure differences are developed.

The various forces have been discussed separately; now, since most occur together these combinations will be considered. Start first with a normal bronchial tube and alveolus, which will be called alveolus X and an alveolus with an obstructive tube which will be alveolus Y. (see Diagram 6) As has already been pointed out, there will be a certain amount of turbulence developed in the obstructed area with a reduction of air flow and a reduction of ventilation of this particular alveolus on inspiration. In an effort to cause sufficient ventilation, there will be a greater negative pressure developed so that alveolus X is over-distended in relation to alveolus Y due to the increase in pressure necessary to cause sufficient ventilation. With this increased negative pressure, there is increased blood flow by both alveoli during inspiration, but there is disproportionate ventilation or disproportionate interpulmonary mixing. The blood supply coming by X can only carry a certain maximum amount of

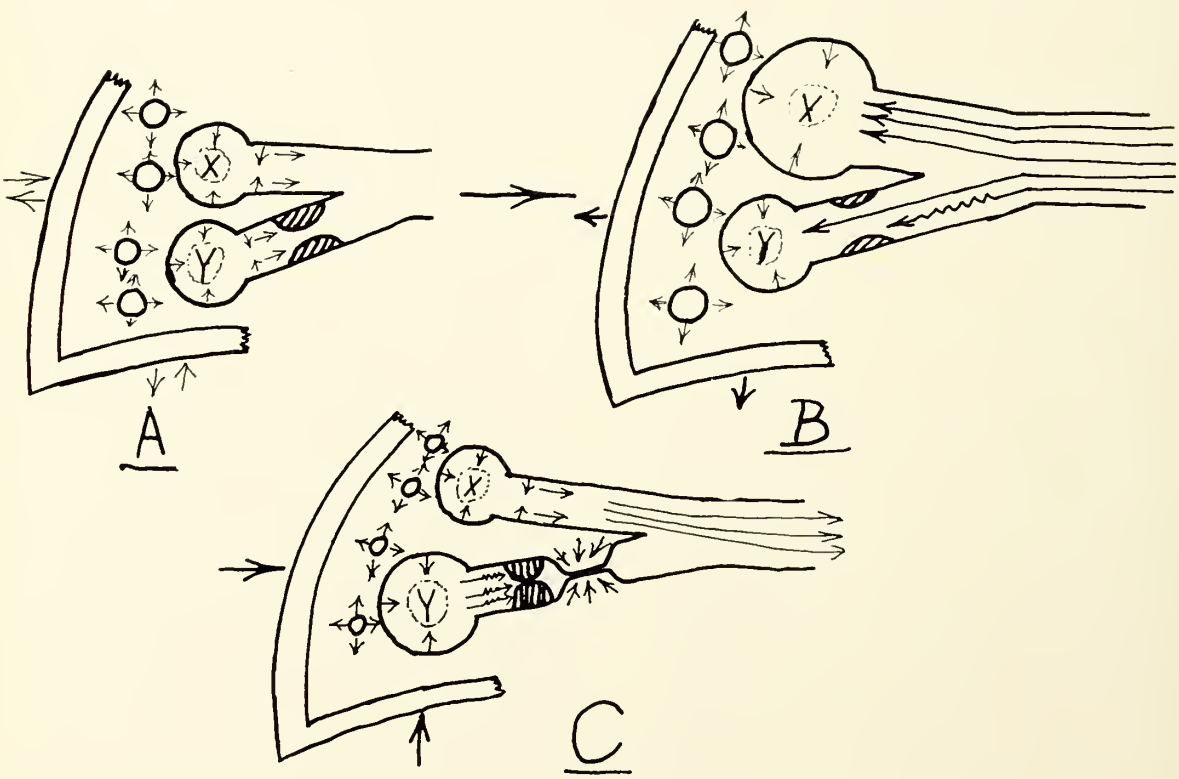


Diagram 6

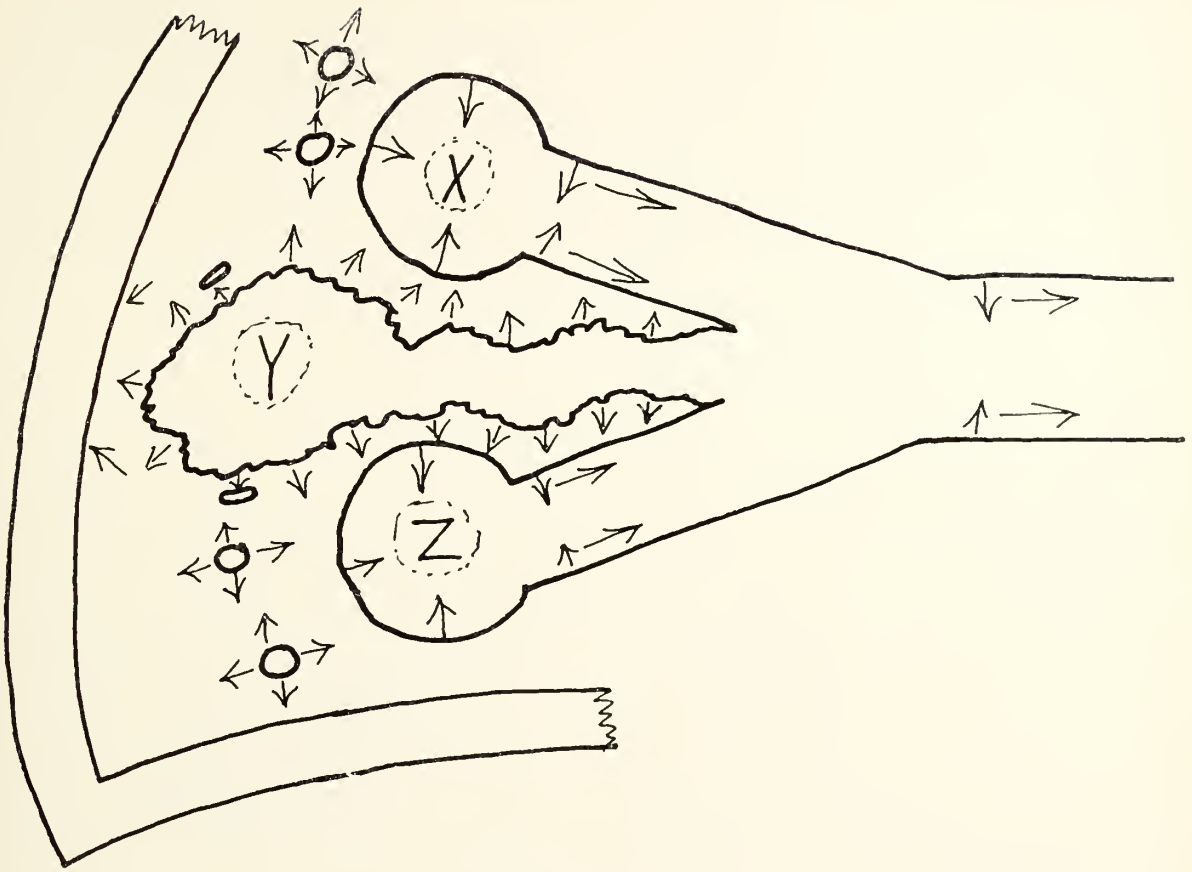


Diagram 7

oxygen and would have carried that amount had this alveolus not have been over-distended. Therefore, there can be no increase in the oxygen saturation of the blood going by X. Conversely, the carbon dioxide given off into the alveolus depends on the degree of ventilation and since X is hyperventilated more carbon dioxide will be eliminated through this particular alveolus and the blood leaving this alveolus will be normally saturated as far as oxygen goes but low in carbon dioxide content. The blood supply going by alveolus Y on inspiration equilibrates with the gases in alveolus Y. Since this alveolus is obstructed it does not empty well due to the obstruction. On the next inspiration it does not receive as much inspired fresh air and contains more retained old air. This produces an increase in carbon dioxide tension and a decrease in oxygen saturation which equilibrates the blood going by alveolus Y. Therefore, blood leaving alveolus Y will have a lowered oxygen saturation and an elevated carbon dioxide level. As this blood mixes in the pulmonary vein going to the left heart, it was derived from one arteriole with normal oxygen saturation and one with a low oxygen saturation. As the blood mixes there is produced less than normal oxygen saturation in the arterial blood. Conversely, there is one arteriole with elevated carbon dioxide and one with reduced carbon dioxide and they even out so that carbon dioxide levels remain the same. In the obstructive patient, as has been demonstrated with these diagrams, the bronchitic patient is the so called "blue-bloater" because the arterial oxygen saturation is decreased. but with the carbon dioxide levels remaining essentially normal. There is now needed greater negative pressures for inspiration and possibly greater positive pressures for expiration so there is an increased flow during inspiration and a basic decrease in flow

during expiration. Thus, there is a greater variation in circulation through the lungs secondary to this disease condition.

Next is a combination (Diagram 7) in which there are two normal alveoli and bronchial tubes along with an emphysematous alveolus and bronchial tube. Here, the situation is somewhat different. As one begins to breathe in the alveoli and bronchial tubes X and Z are normal and must be forcefully expanded by the chest cage and diaphragm. The emphysematous area Y with its tubes has lost its elasticity, is rather large and offers little or no resistance to either inspiration or expiration. Therefore, as the chest cage starts to move out to increase the thoracic cage volume, the first areas expanded will be these areas. As previously discussed, these have usually lost most of their circulation, have a lot of scar and fibrous tissue in the surrounding interstitial area and contribute very little, if any, to ventilation. After these areas are expanded then the pull of the chest cage on alveoli and bronchial tubes X and Z can again become effective as normal with increases in these bronchial tubes length, diameter, and alveolar size. Thus, as the chest cage first moves there is little change in the interstitial pressure with the alveoli changing little until all the emphysematous areas are full at which point there begins to develop a negative pressure to expand the normal alveoli. In so doing increased volumes must be ventilated. There is an increased effort required for this increased ventilation. As expiration begins then the alveoli and bronchial tubes X and Z tend to return to their normal state and collapse rather rapidly as in the normal. The chest cage continues its collapse. Since there are pulls by the normal bronchial and alveolar structures then Y is kept open as this collapse continues. If Y is to be emptied, it will require an increased force which will still be retarded by the normal structures. In these areas air can be trapped and Y may remain full even following expiration, thus further interfering with breathing. If there are a large number of Y-type alveoli throughout the lungs, then there is a large area of air containing cavities that do little or no work, some of which may let the normal elastic structures collapse far beyond normal to the point of closure of the bronchial tubes and alveolus. This is spoken of as surfactant atelectasis. As the number of the air spaces of the Y-type increase there tends to be a marked increase in the work required to breathe. There is also loss of pulmonary capillary bed in relation to alveolus. In these situations, the blood that circulated through the lungs, as a rule, does handle carbon dioxide and oxygen normally and therefore, even though the patient is short of breath, the blood stays well oxygenated and carbon dioxide levels, as a rule, stay fairly close to normal. The strain that is produced on the heart in this type situation is primarily due to increased peripheral resistance in the pulmonary arteriolar bed due to the actual loss of arteriolar and capillary vessels. Therefore, this individual who stays oxygenated and is very short of breath is frequently referred to as the "pink puffer." In the two instances we have seen the clinical differentiation between the bronchitic or "blue bloater" and the emphysematous patient or the "pink puffer."

In a further combination, as in Diagram 8, there is a combination of conditions which is the rule in chronic lung disease. This combination includes, as seen in A, an obstructed alveolus (X), an emphysematous area (Y), and a normal alveolus (Z). These have been covered separately. Now visualize this situation: as inspiration begins, area Y fills first which is rather easy to fill with no resistance. As the chest cage increases in size, after there is developed sufficient negative pressures to cause expansion, air begins to fill the normal alveolus Z. As flow rates increase, turbulence develops with poor ventilation of alveolus X; therefore, a much greater effort is required in order to ventilate this lung with both obstructed and emphysematous changes and much greater pressures are necessary to cause inflow of air. Therefore,

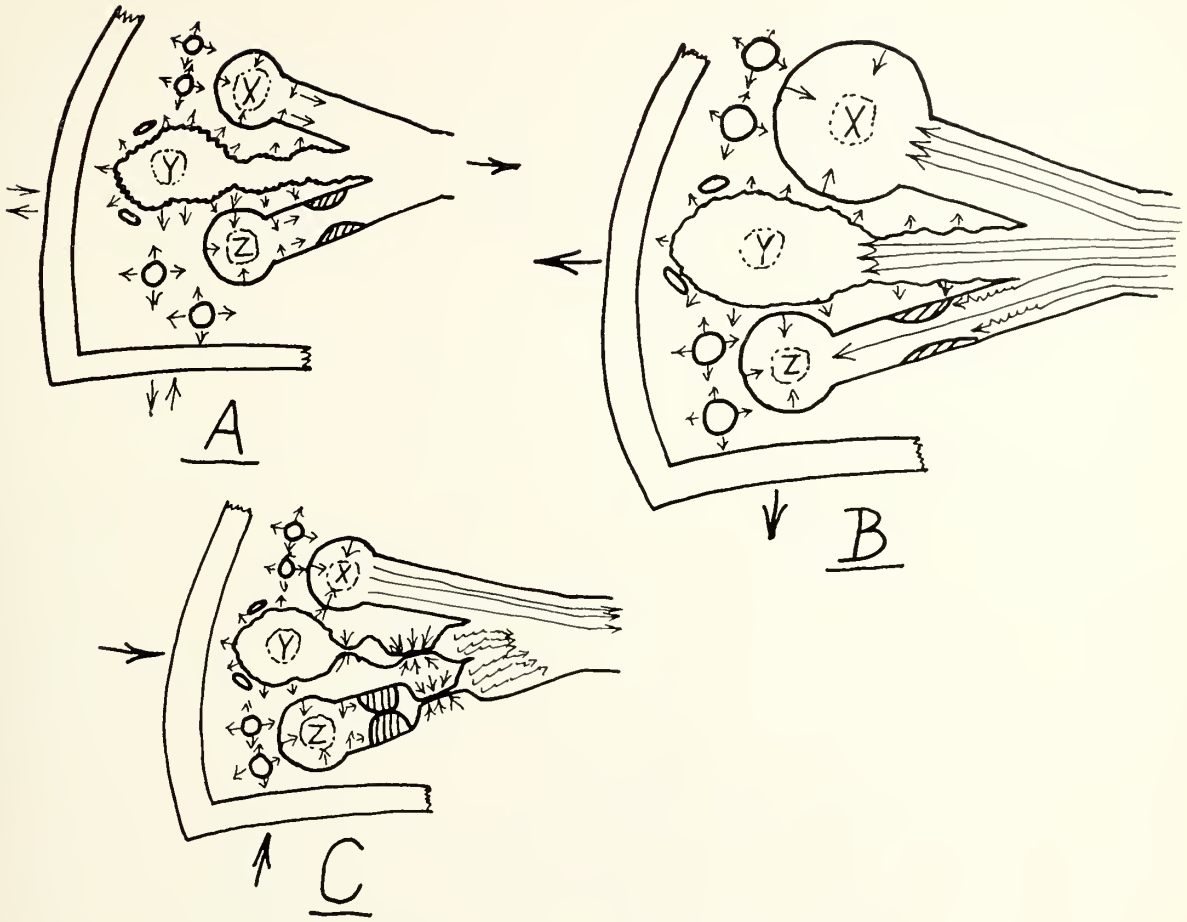


Diagram 8

there is over-ventilation of alveolus Z. Turbulence causes poor ventilation of alveolus X. Both of these may be receiving good supplies. There must be volume exchange sufficient to keep alveolus Y from being a problem. As inspiration is completed and expiration begins, alveolus Z empties rapidly and normally. There is retarding and trapping behind the obstruction in X which still has elasticity keeping Y half open. At this point the chest cage has to act forceably and develop a positive pressure which causes bronchiolar collapse to both X and Y with trapping of air. Y has very little blood supply. X has a normal blood supply, and the only area normally exchanging gases is the alveolus Z. As previously mentioned, in X, as this sort of thing occurs carbon dioxide levels get high; oxygen levels get low. There is little if any change in the gases in Y. There is not the ability to over-ventilate in Z that there was when it was just the obstructed and the nonobstructed alveolus. Therefore, an extreme effort is necessary to breathe. As this trapping occurs, then the volume remaining in the lung gets greater, which means that the chest cage volume at the resting state is larger with more air remaining with which to be mixed at the next inspiration and with extremely poor interpulmonary mixing, poor circulation, and arterial oxygen saturation going down as carbon dioxide levels begin to rise. On inspiration the first air to go from the bronchial tubes to the alveoli is that air which was in the bronchial tubes at the end of expiration. As inspiration continues, then the outside air moves first into the bronchial tubes and then into the alveoli. With the situation such as in Diagram 8 or any of the diagrams here present, the air in the bronchial tube at the end of expiration has low oxygen satu-

rations and arterial CO_2 levels. When the next inspiration begins then this is the air that first enters areas such as Y and X. As breathing continues CO_2 rises and the oxygen saturations in these areas continually goes down until a new level is reached. There is little or no way to flush these areas out. So, in actuality, there are reduced arterial oxygen saturations, possibly increased arterial CO_2 concentrations. Because of the changes in the arteriolar bed there are greater pressure changes in the pulmonary circuit which cause a greater force of contraction by the right heart to maintain pulmonary circulation. With the low oxygen saturation and increased carbon dioxide tension there is further stimulus to arteriolar vasoconstriction and pulmonary hypertension. As these continue in a spiraling fashion there slowly develops extreme pulmonary artery pressures followed by right heart failure. If there is added to this picture thickened alveolar membranes with poor oxygen transfer across the membrane, it is not hard to visualize how right heart failure (cor pulmonale) develops. It is easy to understand the reason for the increased effort in breathing that does occur. It is also easy to understand the various complications that may occur to a greater or lesser extent in chronic restrictive and obstructive lung disease. These conditions can be treated with expectorants, bronchodilators, mucolytic agents, exercises and mechanical devices. With the proper exercises we can prevent trapping. It is important to be able to evaluate the lung and these various components, along with severity of abnormality. One would like to be able to—and can—measure (1) the ability to get air in and out of the lungs (2) the amount of air normally breathed (3) the interpulmonary mixing of this air (4) the transfer of gases across the membrane (5) the efficiency of the transfer or the blood gases as a result (known as diffusion) and get some idea of the degree of trouble or abnormality. Diseases can be classified as restrictive disease, obstructive disease, loss of elasticity disease, diffusion difficulties, and interpulmonary shunting of blood or passing of blood by nonaerated areas so that it ends up in the left side of the heart the same as it entered the pulmonary artery.

Carbon dioxide levels rise in lung disease due to the various disturbances previously mentioned such as poor interpulmonary mixing, large amounts of shunting of blood, or obstructive processes that retard the ventilation of CO_2 out of the lungs. As the arterial PCO_2 goes up as a rule above 70 mms. of mercury pressure then the respiratory center loses its sensitivity to carbon dioxide and, to a great extent, also to pH. At this point the carbon dioxide-bicarbonate buffer system is no longer an effective buffering system. Carbon dioxide is the retained acid and there is a respiratory acidosis. As this occurs, oxygen begins to be the driving factor of breathing. As arterial oxygen saturations fall and this is sensed by the carotid bodies (in the carotid artery at the angle of the jaw) there is stimulation to breathe which raises the arterial oxygen saturation. As it approaches normal, breathing slowly slows and apnea occurs until oxygen falls again to a level sufficient to cause the respiratory center to activate. This is known as cheyne-stokes respiration. In opposition to this, if the individual becomes conscious of his breathing and frequently excited, he will breathe too deep and fast, blow off too much CO_2 and thereby cause the blood to become alkaline with all the symptoms secondary to hyperventilation. Thus, CO_2 and pH are the prime controlling factors of respiration. Where there is disease that causes a rise in CO_2 beyond a point, then there is a fall back on oxygen saturation as a controlling factor. It is in these individuals that oxygen at very high levels through simple diffusion without respiration can maintain oxygen saturations perpetuating the apnea, carbon dioxide levels continue to rise and may reach lethal levels.

The clinical pulmonary physiology lab is designed to evaluate conditions present and the degree of severity. After treatment improvement can be clinically and objectively evaluated.



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

NOW IS THE TIME... TO GIVE HER TIME WITH OVULEN-21®

Each tablet contains ethynadiol diacetate 1 mg., mestranol 0.1 mg.



The new mother needs time . . .
to adjust to motherhood,
to give her new baby all the love
and attention he requires.
She needs time for her husband . . .
and for herself as well . . . .
so that she can come to terms
with the increased cares
and responsibilities now facing her.
She needs time to decide
when she will have additional children
and how many she will have.

OVULEN-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

GIVES HER TIME

Your prescription for Ovulen-21 gives the new mother time to meet her family's present needs...to plan for her family's future.

She can take Ovulen-21 confidently and comfortably month after month. Its dependability is enhanced by its simplicity of use. A woman needs little or no time to learn the simple Ovulen-21 regimen: three weeks on—one week off. And the automatic record-keeping of the petite, virtually "patient-proof" Ovulen-21 Compack® helps to maintain her schedule...helps put time on her side.

Immediately post partum is the time

It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

It is also the most opportune time, since she is conveniently present in the hospital, for her to be given both instructions and a prescription.

Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thrombaembalic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.



Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestagen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

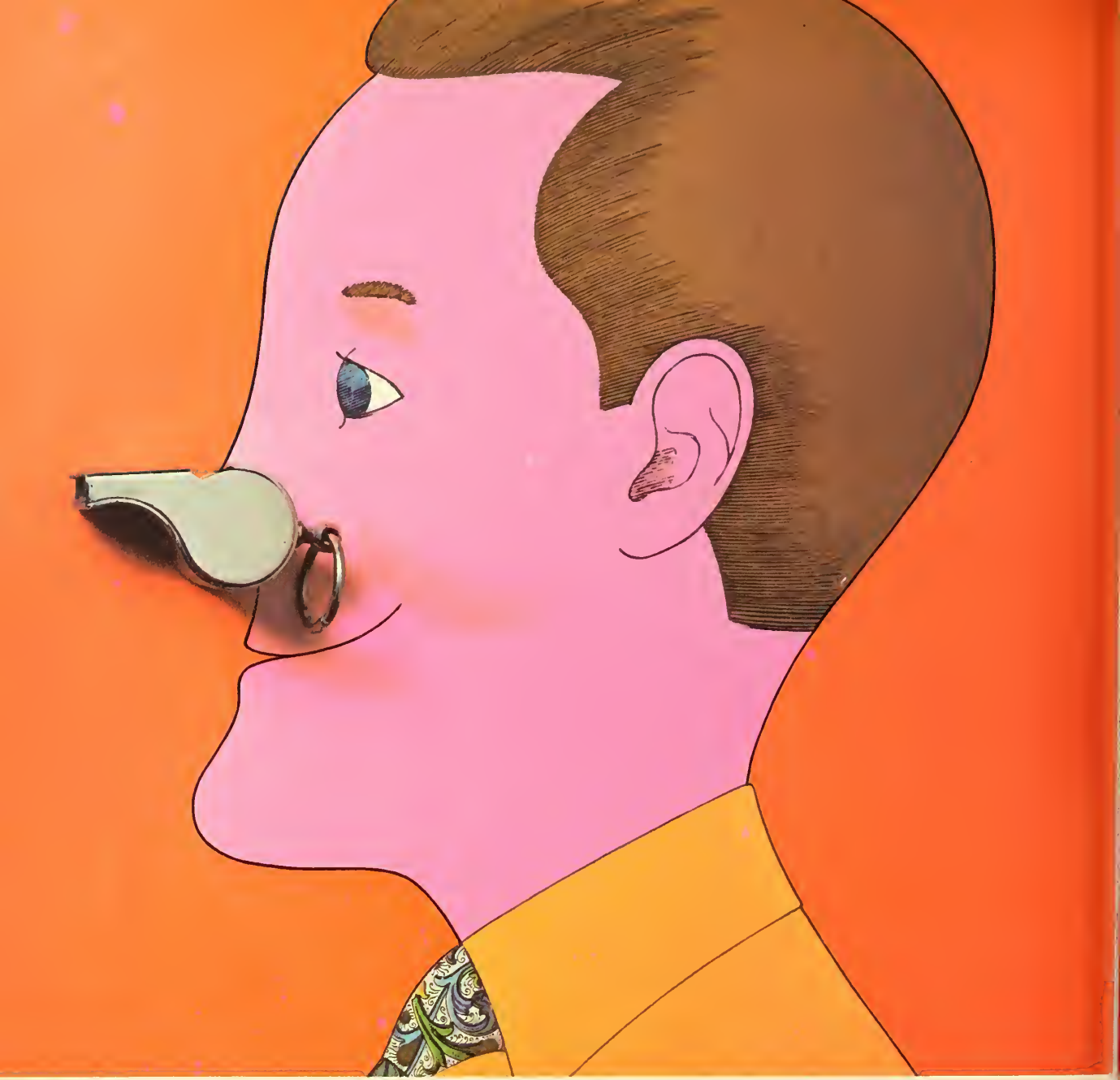
Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching. The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see complete prescribing information.

Where "The Pill" Began

G. D. SEARLE & CO., P.O. Box 5110, Chicago, Ill. 60680 SEARLE



Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS

With Friends In Congress, GaMPAC Looks At Legislature

by William J. Mahoney, Jr.

Executive Director, ALAPAC

The eight-year history of one medical Political Action Committee is a meaningful success story, as presented by a professional politician at a GaMPAC "workshop" in the Atlanta Biltmore.



Rep. Hagan

G. Elliott Hagan, who went to Congress from Georgia's First District November 8, 1960—only months before the birth of the American Medical Political Action Committee (AMPAC) and just over a year before GaMPAC was created—served as keynoter for the second biennial working conference of the awakened Georgia doctors.

Doctors of his district helped elect him to Congress in the first place, he told his interested audience, and "but for GaMPAC with its doctors and doctors' wives scattered over 20 counties comprising my district, my first term might have been my last."

Georgia's Republican and Democratic leadership, evenly divided, participated in a panel discussion, "Strictly Politics," and in speeches on "Working With the Party."

Roy Pfautch of St. Louis, president of Civic Services, Inc., a political management group; Hal Suit, WSB-TV News Director; and Blair Henningsgaard, M. D., Astoria, Oregon of AMPAC's Board of Directors, its immediate past chairman, were other speakers. And the consensus was:

Medicine has come of age, along with the science of political management.

You are rolling back the forces of neo-federalism.

You have won, even when you seemed to lose. (Cited as an illustration was one Georgia Congressman, unnamed, rated originally by ACA at 43%, who, with each desperate campaign for reelection has become more and more conservative, until today he is rated by ACA at 80%!).

You have changed the face of Congress in the last six years.

But now you must look to your *State Legislature.*

GaMPAC interested itself in 18 races for the Legislature in 1968, it was pointed out. It lost only one of those 18 races. And the trend is national, the importance of having friends of medicine in the 50 Legislatures becoming more apparent as Congress comes more and more to tip its hat with some respect to organized medicine.

"God, Motherhood and Country are excellent affirmative platforms only so long as your vote leadership isn't made up of atheists, bastards and traitors," one speaker flippantly told the workshop.

"Doctors in AMPAC and its 50 affiliated PAC organizations must become toughly realistic in their assessment of candidates, with the sense to demand *total* knowledge, the courage to take the strengths and the weaknesses of each candidate and weigh them against the voters who will elect or reject them," said another.

Impetus to involvement is a basic love of

country, it was pointed out. Asked what she thought of our United States, a visiting Czechoslovakian feminist responded: "I like everything about America except where you are going." Explaining, she compared it to the last days of her country:

She was the wife of a small town mayor. Police had shown at their door one day. She never saw her husband again, and she was herded with 11 other women leaders in the basement of a church, left there 24 hours. Once the door opened and the 12 were invited to draw straws. The Mayor's wife drew the short straw. Hours later she learned that this short straw entitled her to look on while the other 11 were executed. And don't think it can't happen here, she added.

Doctors were not the first to be rated contemptuously as political "zeros," it was pointed out at the one-day workshop. Forty years ago, Labor was in the classification. In the 1930s a group of very determined men, tough-minded realists in the ranks of organized labor, sat down to weigh the situation. They recognized that political independence made them politically ineffective.

Such labor leaders as Walter Reuther and Sidney Hillman recognized that in Franklin Roosevelt labor had a friend. It was resolved to elect to Congress men and women who owed their election in whole or in part to labor. They determined quickly that their weapons were money and manpower. And as a clear indication of the fast success of their efforts, it became President Roosevelt's flippant retort to any petition that one "clear it with Sidney" (Hillman).

When AFL and CIO merged, COPE became the most powerful political minority in United States history. As one of the speakers pointed out, "In the 1960 general election, COPE influence was incalculable. It was the difference between resounding defeat and Kennedy's skin-of-his-teeth victory."

Meantime, Representative Hagan said, the voice of medicine had become inaudible, despite the fact that there have been doctors in political leadership and "in the Congress from 1774 to the present 91st Congress. They have been there, not because they were doctors, but because of love of country and concern for its course."



EXPERTS TOLD GaMPAC where to go. From left (top): Wiley Wasden, chairman, Georgia GOP; Joe Sports, secretary, Georgia Democratic Party; Hal Suit, Director, WSB-TV news; from left (bottom): Blair Henningsgaard, M. D., AMPAC board director; Roy Pfautch, president, Civic Services, Inc., St. Louis; Luther Vinton, M. D., 4th District GaMPAC chairman, program moderator. (Photos courtesy James M. Moffett, GaMPAC executive director)

The distribution of medicine is a continuing problem, the meeting was told. It should be controlled by those who know most about it. "But be very sure that, if the doctors renege on their responsibilities, another group —quite possibly COPE—will determine the way of that distribution."

There was humor to spark the Atlanta program.

Dr. Henningsgaard opened with the story of the tippling passenger on the Titanic (which struck an iceberg and sank on April 15, 1912). He looked out his porthole and exclaimed: "I did order ice, but this is ridiculous."

Wiley A. Wasden, Jr., chairman of the Georgia State Republican Party, recalled that when Senate Chaplain Edward Everett Hale was asked: "Do you pray for the Senators?" he replied: "No. I look at the Senators and pray for the country."

Luther M. Vinton, Jr., M. D., of Decatur, serving as master of ceremonies, quoted one successful speaker as saying that he always stood on one foot through his speech, knowing that leg would tire before his audience did.

Responded Hal Suit, WSB-TV News Director, who lost a leg in World War II: "It wouldn't work for me!"

Thirty-Third Annual Meeting The New Orleans Graduate Medical Assembly

The thirty-third annual meeting of The New Orleans Graduate Medical Assembly will be held March 2, 3, 4, 5, 1970, headquarters at The Roosevelt Hotel.

Nineteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The program will include 50 informative discussions on many topics of current medical interest, in addition to a clinicopathologic conference, symposia, medical motion pictures, round-table luncheons, and technical exhibits. This program is acceptable for twenty-two (22) prescribed hours and nine (9) elective hours by the American Academy of General Practice.

An interesting and enjoyable program of entertainment for visiting ladies has also been planned.

Of special interest will be a one-day pre-Assembly symposium scheduled for Sunday, March 1 on "The Price of Medical Progress" presented by noted authorities. This symposium is acceptable for six (6) prescribed hours by the American Academy of General Practice. This session will be strictly limited to physicians and their wives.

For further information, contact Secretary, Room 1538, 1430 Tulane Avenue, New Orleans, Louisiana 70112.

Arizona Pesticide Intoxications

Intoxications by pesticides represent only a very small fraction of the total reported poisonings in Arizona. In agricultural areas, however, unreported intoxications undoubtedly occur with some regularity, and the prevalence of household pesticides constitutes a continuing threat to small children. The success of treatment is determined by the dose and nature of the poisoning agent, by the promptness with which unabsorbed poison is removed, and by the appropriate use of antidotes.

The dependence of agriculture on a wide variety of potent insecticides is not likely to change in the near future. Currently, long-term ecologic considerations are forcing abandonment of the persistent chlorinated hydrocarbons in favor of the degradable but much more acutely toxic organophosphates. Termite and household pest control still rely heavily on chlorinated cyclodienes and cyclohexane, but a number of "low toxicity" organophosphates, and carbamates are gaining popularity. Thus, exposure of the public to an assortment of new chemicals is currently substantial, and is unlikely to diminish in the foreseeable future.

Acute poisonings usually fit either of three categories: 1) ocupational, 2) home accidents, or 3) suicides.

—*Arizona Medicine*

Internships

William C. Walley, M. D.
Mobile, Alabama

For the majority of senior medical students the choice of an internship is not an easy one. Innumerable variables and idiosyncrasies, on the part of both student and hospital, necessitate the selection of an internship on a truly individualized basis. Thus, when one speaks of "internships," only generalizations are apt to endure under the onslaught of biased and individualized scrutiny.

With the foregoing thoughts in mind, the author hopes to present some ideas which may help the prospective intern select an optimum internship.

I. *Why Internships?*

Perhaps it is pertinent to inquire into the reasons for the existence of an internship phase of graduate medical education. The primary purpose must be educational—extending and refining the basic general medical knowledge of the student. The secondary purpose is probably that of service to the patient and hospital. Numerous ramifications of these major facets of internships exist:

1. Assumption of more responsibility of patient care.
2. Development of a justified self confidence in one's ability to deal with sick patients.
3. Development of a satisfactory and meaningful patient - family - physician philosophy.
4. Increasing one's diagnostic acumen and therapeutic practices.
5. Teaching, if in teaching hospitals.
6. Preparation for residency training.
7. Meeting requirements for state licensure (since 37 states require completion of an approved 12-month internship for certification).
8. Many others.

Certainly each of these factors is weighted differently depending on the type hospital—university, non-university teaching, or community. Each should be considered in the eventual educational ambitions of the student.

Many students consider the internship a necessary evil and would prefer entering a residency program immediately after graduation from medical school. Indeed, the Citizens' Commission on Graduate Medical Education (Millis Report) recommended ". . . the internship, as a separate and distinct portion of medical education, be abandoned, and that the internship and residency years be combined into a single period of graduate medical education called a residency and planned as a unified whole."[1] This concept is partially realized through the "straight internship." Many medical educators no doubt are seriously considering the abolition of the internship *per se*. Until then, however, seniors must contend with the selection of an internship *and* residency. Students should bear in mind the principle advocated by this portion of the Millis Report; namely, the unified and integrated continuum of postgraduate medical education.

II. *Factors in Selection of Internship*

What are the factors one should consider in selecting an internship?

A. *Type of Internship.* One first must make a decision concerning the type of internship he desires. One's choice of a parti-

Dr. Walley is presently interning at Mobile General Hospital.

cular medical career in many cases dictates the type of internship he should seek. Few absolute and firm regulations concerning internships with respect to residency training programs exist; for example, a few university-affiliated hospitals demand a straight surgery internship as a prerequisite to surgical residency training. This appears to be an increasingly popular trend in several specialties. The senior student should thoroughly investigate such policies in the hospitals he considers for intern and residency training.

Students, in deciding the type of internship desired, may be categorized in three groups:

1. Those who have decided definitely upon a specific medical career.
2. Those who are still contemplating several specific fields.
3. Those who are completely undecided as to a specific medical career.

For the first group (those who have decided definitely upon a particular medical career) the task of deciding which type of internship is most appropriate should be relatively simple; e. g., one contemplating a career as an internist no doubt will choose a straight medicine internship; one desiring an eventual pediatric practice will prefer a straight pediatric or perhaps a mixed pediatric internship.

Those in the second group who have narrowed the field of choice to two or three still have a relatively easy chore deciding which type internship to seek. A mixed internship including rotation through one or two desirable electives may ideally meet the students' desires. Straight medicine internships can be adapted to (and indeed may be most beneficial) any type of residency training since they provide a firm basis for future training in any field; indeed, this basic medical knowledge is necessary for the good practice on any of the medical specialties.

Those students who are completely uncertain of their eventual career goals face a more precarious situation and one which may later "close some doors" to them. Presently this rarely occurs, but as the "straight" internship is more widely acclaimed, the more likely are residencies to be awarded to those with the appropriate "straight" internship. The statement, "If uncertain, do a rotating internship," has been made often, especially by the medical student. This prescription certainly is not a panacea for the indecisive. It is actually not to the student's benefit in any way to postpone his decision about eventual career goals beyond the beginning of the senior year. This is true for two reasons:

1. Six months of senior clinical services largely repeat junior clinical experiences; these senior services will not suddenly provide him with immense knowledge and foresight, enabling him to make a much wiser choice of internship type.
2. His choice of a residency must be submitted to appropriate hospitals within 1-3 months of commencing his internship (unless he is entering the military service).

Perhaps the wisest course of action for the indecisive student is that of selecting one specialty (including family practice) from those that are not disliked, becoming sincerely interested and engrossed in this field and directing his efforts to acquiring good intern and residency training to achieve an excellent and enviable practice in this specialty.

Having decided upon a particular type internship, what parameters should one then define in selecting the ideal internship for his distinctive situation?

B. *Education.* The primary purpose of the intern year is education! Any program which fails to recognize this truism is not only failing to meet the "Essentials of Approved Internship" set forth by the Council on Medical Education,[2] but, even more important, it is depriving the intern of a truly maximal learning experience. Appropriate are the words of Dr. John Nunemaker, "Im-

balance in the proportion of any program which makes services primary and education secondary is the surest symptom of deterioration and eventual failure (of graduate medical education)." In referring to hospitals who always fill their intern slots 100 per cent, he says they have one thing in common—". . . dedication of the medical teaching staff to high principles of graduate medical education."[3]

How does one evaluate the real quality of education purported by the many approved hospitals? Levit et al.,[4] reported the most objective evaluation of interns' educational experiences in 1964 through use of National Board Examination scores. This study is of sufficient merit to reprint the summary and conclusion:

"The study reported here was undertaken to obtain factual information about the effect of various characteristics of hospitals with respect to the caliber of interns attracted to the internship program (defined as input), and the competence of interns after one year of internship (defined as output). Measures of input were derived from the scores of 2400 National Board candidates who took Part II as they graduated from medical school. Measures of output were derived from the Part III scores of these same individuals at the end of internship in 321 approved hospitals.

The effects of six hospital characteristics were studied: (a) medical school affiliation, (b) percentage of internships filled, (c) monthly stipend, (d) hospital size, (e) hospital control, (f) type of internship offered. Because the first of these characteristics, medical school affiliation, was expected to have a dominant effect upon the other characteristics under consideration, the remaining characteristics were studied separately for affiliated and non-affiliated hospitals.

Within the limitations described in this study, the data support the following conclusions:

a. With regard to input or caliber of intern obtained (as measured by Part II), (1) affiliated hospitals obtained interns of significantly higher caliber than did non-affiliated hospitals, (2) affiliated and non-affiliated hospitals filling more than 75 per cent of their internship positions obtained interns of significantly higher caliber than those filling less than 75 per cent of their internship positions, (3) affiliated hospitals offering only straight internships obtained interns of significantly higher caliber than affiliated hospitals offering only rotating or mixed internships, (4) amount of monthly stipend, type of hospital control, and hospital size showed no significant effect with relation to the caliber of intern obtained in either affiliated or non-affiliated hospitals.

b. With regard to output or clinical competence at the end of one year (as measured by Part III), (1) in the affiliated hospitals the level of output was significantly higher in those hospitals that filled more than 75 percent of their internship positions, (2) in the non-affiliated hospitals, although amount of stipend bore no relationship to the caliber intern obtained, the level of output was significantly higher in those hospitals that offered a monthly stipend less than $200 (sic 1960 figure), (3) none of the remaining characteristics showed any significant effect in relation to the competence of interns after one year of internship."

It should be added that the conclusions stated above represent the *net increase* in clinical competence; the value of the internship in increasing one's clinical competence was arrived at by "subtracting" NB II (input) from NB III (output) in a valid statistical manner, thus in effect measuring the *accumulation* of *clinical* knowledge. Part III NB Examination is based largely on practical clinical application of one's medical knowledge. Part II NB is largely a measure of general basic medical knowledge with much less emphasis on clinical application. Because of this fundamental difference in concept and emphasis in these two examina-

tions, the results may not be entirely representative of the actual educational benefits, but they do represent a good first effort to quantitate the educational benefits accrued from the internship.

Parameters one should consider in evaluating the educational aspects of the prospective internship are many. The following are certainly foremost in importance:

1. Quality, number and source of members of the teaching and house staffs.

A hospital staff composed of members from many different medical schools and hospitals constitutes a melting pot of ideas, concepts, principles, and philosophies regarding even "simple and straightforward" diagnostic and therapeutic problems. This is indeed a stimulating and thought-provoking situation which provides the intern with new and varied approaches from which he may select the one method or combination which he feels is most appropriate. He thus acquires a more complete understanding of the particular situation and increases his stock of possible remedies for future problems. A house staff composed largely or exclusively of members from the same medical school and hospital begets a stagnant atmosphere of mutual agreement without significant new ideas or approaches to problems; a less stimulating and inferior internship results.

There still exist internships at hospitals with no residency programs. These internships are offered by small, non-affiliated community hospitals staffed by private practitioners who are so obligated to their patients' welfare that the intern is deprived of a satisfactory educational experience—service has become primary and education a poor second! This situation may result in an inferior residency appointment for the intern and ultimately an inferior formal medical education which will be reflected in his practice.

A hospital filling a relatively small fraction of its intern and resident positions deprives the intern of close and frequent contact with his peers and is likely to create a situation requiring him to assume care of more patients than is educationally beneficial to him. A large percentage of his time is spent on routine procedures; e.g., dictating, writing, scheduling, and performing other menial tasks. Consequently, much less time is available for thinking, reading, discussing, and thoroughly investigating particular aspects of a patient's problems. He is entrapped by a situation requiring him to use and reuse present knowledge.

It is self-evident that staff members should be highly-competent clinicians with adequate time to devote to teaching chores. World-renowned researchers and ultra-specialists do not necessarily, by any stretch of the imagination, provide the utmost in clinical teaching. Interns, residents, medical students and staff members must all interact to generate an atmosphere conducive to optimal achievements of all concerned.

2. Teaching rounds.

The student should inquire about the frequency and general conduct of these rounds. Are they truly learning experiences? Is the intern questioned and asked to substantiate his diagnosis and therapy? Are rounds conducted promptly and regularly? Are the attending men interested in teaching *per se*, or are they required to perform in order for the hospital to maintain its approved internship and residency programs?

Teaching rounds should be directed strictly to exchanging information between intern, resident, and staff member. They should not be intended for handling routine "work" details, nor should they be periods of idle gossip or socializing. To be maximally beneficial they must be stimulating and thought provoking with provocative enticement and requirement for participation by all present; they should not be more than 1½-2 hours' duration 3-4 times per week. They should be actively spent in discussion of new, interesting, and unusual problems with appropriate approaches to their solution. Interns and

residents should be freely drawn into discussion and constantly "put on the spot" to defend their diagnosis and prescribed course of treatment. This encourages the intern to develop a logical and critical inquiry into the fundamental principles of diagnosis and therapy.

3. Patient responsibility (well supervised or otherwise).

How much patient responsibility is allocated to the intern? How much responsibility does he have with private versus "clinic" patients? Is adequate supervision provided? Must he seek approval for all proposed diagnostic and therapeutic procedures? Is he required to justify and substantiate his requests and actions? These are but a few of the questions one should try to answer concerning a given internship.

No one will argue with the thesis that full patient responsibility is a tremendous stimulus to conscientious and devoted involvement by the intern and is, no doubt, one of the major requirements for a productive internship. However, in conjunction with patient responsibility, the intern's actions and practices should be fully scrutinized by the resident and hospital staff members. A delicate balance of patient responsibility and staff supervision must be reached and individualized for each intern. Constructive criticism should be welcomed by the intern; without it he would profit just as well by being in private practice learning by "trial and error." Contrary to popular belief, unlimited and unsupervised responsibility does not provide the maximal learning experience.

4. Availability of staff members for consultation and medical advice.

The unavailable and hard-to-reach staff member, perhaps actively engaged in pursuit of his private practice, is one of the major complaints of many interns in small, unaffiliated community hospitals. Problems arise which require prompt consultation and solution for optimal outcome and the most meaningful educational experience for the intern. If no superior advice is readily available, the intern must "play it by ear," so to speak, with either disasterous, mediocre, or excellent results. The final outcome may in no way relate to the intern's logic for instituting given measures and should he, in his busy schedule, fail to discuss the situation in detail later with a staff member, erroneous information from this experience may be incorporated into his stock of medical knowledge. The ready availability of a staff member or resident would definitely reinforce his correct ideas and depreciate his incorrect ones concerning the problem. Simply stated, good clinical teachers who enjoy teaching and are readily available to do so greatly enhance the interns' learning experience.

5. Staff reputation.

Reputations which are widespread and general, be they good or bad, usually have a justifiable basis. For this reason it is wise for a senior to solicit the opinions and advice of staff members of his school and other appropriate acquaintances concerning the medical staff at familiar hospitals; younger staff members and residents who have recently been associated with a particular hospital's training programs often supply excellent "inside" information to the student. Certainly one should seek out those individuals for detailed information concerning potential internships. The student should realize, however, that almost anyone will highly extol the virtues of the particular training program he chose. Albeit, one may obtain useful information by direct questioning about specific points.

Reputations may be based on particular limited facets of the hospital and staff. Certain hospitals are exceedingly renowned for their research efforts and personnel; however, their clinical training may not be held in so high esteem. The "top 10" hospitals for internship training are especially recognized for their excellence in training academicians for teaching and research careers.

(Continued on Page 683)

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieve by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.



Contraindications: Edema, danger of cardiac decompensation, history or symptoms of peptic ulcer, renal, hepatic or cardiac damage, history of drug allergy, history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the dr should be discontinued with the a pearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediate before or after meals or with milk minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative derm

Sandy sails again! After an arthritic flare-up.

His rheumatoid arthritis flared out of aspirin control. It meant weeks of pain, stiffness, swelling and tenderness...and a lot of sun and wind that somebody else took advantage of.

Next time, after aspirin, consider Butazolidin alka:
prompt anti-inflammatory effectiveness
short trial period
low maintenance dosage
usual dosage: 1 capsule q.i.d. initially, then 1 or 2 daily

Butazolidin® alka

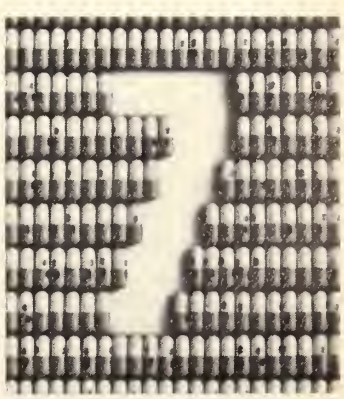
100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

Serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings and contraindications. Read the prescribing information. It's summarized below.

t , Stevens-Johnson syndrome, L ll's syndrome (toxic necrotizing e dermolysis),or a generalized a rgic reaction similar to serum s ness may occur and require p manent withdrawal of medica- t . Agranulocytosis can occur s denly in spite of regular, repeated m mal white counts. Stomatitis a , rarely, salivary gland enlarge- m nt may require cessation of treat- m nt. Such patients should not r ive subsequent courses of the d g. Vomiting, vertigo and languor m / occur. Leukemia and leukemoid r ctions have been reported. While m definitely attributable to the d g, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria, glomerulonephritis and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Rheumatoid Arthritis: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily. In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response. (B)46-070-C
For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502



If it doesn't work in a week, forget it.



Remember how grea milk of magnesia tasted?

Almost as good as castor oil.

But now you can spare the taste buds and spoil the patient with a modern Dulcolax tablet or suppository.

And Dulcolax works so predictably that the time of bowel movement can often be predicted. Tablets taken at night usually produce a bowel movement the following morning. Suppositories generally work in 15 minutes to an hour.

For preoperative preparation, a combination of tablets at night and a suppository the next morning usually cleans the bowel thoroughly.

Dulcolax suppositories may be particularly helpful when straining should be avoided, as in postoperative care. Keep in mind, however, that the drug is contraindicated in the acute surgical abdomen.

Dulcolax®...it's predictab
bisacodyl

Under license from Boehringer Ingelheim G.m.b H

Geigy Pharmaceuticals, Division of Geigy Chemical Corporation, Ardsley, New York 10502

(Continued from Page 678)

Other hospitals with less impressive general reputations provide exceptionally good clinical training. Some offer excellent surgical training, yet only mediocre training in other areas; many variations on this theme exist.

One contemplating a serious and dedicated career in academic medicine, teaching and/or research must consider interning at the more reputable hospitals dedicated to training this type individual. Individuals strictly interested in the private practice of a medical specialty should pursue an internship of excellent repute in training clinicians for private practice in the desired field of specialization. Those interested in becoming "primary physicians" or "family physicians" should seek training in the institutions which are exceptionally well recognized for their efforts.

6. Relative numbers of private and "clinic" or "service" patients.

The intern should be exposed to both types of patients, yet he must be given patient responsibility if he is to prosper in his training. With few exceptions the clinic patient is the chief responsibility of the intern and resident; however, the private patient looks to his private physician for proper diagnosis and treatment. Whether the intern is permitted significant responsibility for private patients' care depends largely on the private physician and the patient. Many private patients resent the intern's actions and responsibilities, thus creating a less-than-optimal educational exercise for the intern. For this reason, a preponderance of service on service-clinic wards may be desirable. It must be borne in mind, however, that 80 per cent (or greater) of interns will enter the private practice of medicine and hence, really need experience with private patients if they are to smoothly execute the shift from formal educational training to practice.

Only after having participated in caring for private patients is one able to realize the economic overtures influencing the practice. Such factors as cost of lab work, cost of radiologic and other diagnostic procedures become very important. When does hospitalization insurance payment commence and terminate, what type work and when may he resume his job, what influence does his financial loss incurred while hospitalized play on his return to good health? These questions suddenly become very meaningful in determining the most appropriate diagnostic and therapeutic course. These factors are real and must be appreciated by the intern and resident.

7. Exposure to social, welfare, rehabilitative, public health, and mental health aspects of patient care.

An intern should learn to consider a patient as a complicated organism living in a highly-specialized world and being an intimate member of a family and a complex society with economic, psychological, sociological, religious, and political problems being met in varying degrees of success or failure. The devices which society has developed to help individuals to meet these problems, whether in health or disease, should be appreciated by the training M. D. He should learn to use these tools effectively in order to fully restore a patient to maximum health and functional capacity in society. All university hospitals and most large teaching hospitals provide exposure to these aspects of patient care; smaller hospitals may not.

8. Exposure to advanced and sophisticated diagnostic and therapeutic tools and techniques.

It is the responsibility of the M. D. in training to make himself aware of the useful "exotic" tools and techniques available perhaps only at large medical complexes which may be absolutely required for proper diagnosis and treatment of a particular condition. Full knowledge of the technique is not required, but awareness of its existence, usefulness, and limitations is a must if one is to practice good medicine. Many of these tools are in use only in medical complexes and

hence, may never be fully appreciated by those individuals training in small community hospitals.

9. Conferences.

The number, type, regularity, quality, intern participation, and distinguished guest participants should all be considered in selecting one's internship. Well-planned conferences and symposia are excellent means of educating the intern and resident and should be an integral part of their daily routine.

10. Emergency Department experience.

Since any physician is liable to be called upon to handle emergency problems, he should be thoroughly trained in an active Emergency Department handling the full spectrum of emergency cases. Full patient responsibility with appropriate supervision and access to any specialty consultation is a necessary phase of an M. D.'s formal training.

The prospective intern should ascertain whether the hospital under consideration has an active emergency room.

11. Menial tasks required.

Occasional routine "scut work" is unavoidable, but if a regular portion of the intern's responsibilities includes such tasks as drawing blood, starting all IV's, administering all IV medications, performing all urinary catheterizations, and staining all sputum and wounds, his time for more gratifying and educational endeavors is seriously curtailed. One should inquire about IV teams, nurses' range of responsibility concerning IV medications, administration of blood and plasma, dictating equipment, and amount of paper work (especially in government controlled institutions). Only by freeing himself of these trivial tasks is one able to devote sufficient time and effort to the acquisition of a good formal medical education.

12. Medical students.

Many feel that medical students are a stimulus to learning. Their questions prompt serious thought and reading by the intern and resident. Their presence infers additional teaching activities in which the graduate medical student may participate.

For those interested in teaching, this provides them a first opportunity to engage in dispersing their knowledge. The old adage that to best learn a subject one should teach it holds true in medicine. The "teaching" intern in many cases will acquire information which his nonteaching colleagues will miss. Thus, association with medical school affiliated hospitals may appeal to many interns, especially those contemplating teaching careers.

C. *Reputation.* As alluded to previously, hospitals and internships, generally speaking, *earn* their reputations. Those with reputations for excellent internships without exception provide the student with unexcelled internship training; those with less exalted reputations offer relatively inferior training. For those individuals interested in careers in research and/or teaching, an internship in a hospital reputed to be foremost in this type of training should be sought. It seems unlikely that any individual interested solely in an illustrious research/teaching career would consider interning in a 250-bed community hospital dedicated strictly to the service of their patients' immediate ills. Likewise, it is inconceivable that one strictly interested in the private practice of medicine would seriously pursue an internship at the "big names." Medical students are indeed a unique breed and certainly unpredictable in behavior and reasoning. The fierce sense of pride and self-esteem characteristic of this group as a whole may be the basis on which many will seek highly reputable internships for the "honor" and sense of achievement derived from successful competition with others for these few slots. Of course, others will be content with more money, fewer hours, and a mediocre learning experience.

D. *Future Educational* Plans. It has become customary for interns to continue their

(Continued on Page 686)



"All Otolaryngologists are Alike"

Just look at them and you can see how much they have in common. Besides, they all go through pretty much the same training, and pass the same kinds of tests, and measure up to the same sort of standards. Therefore, all otolaryngologists are alike. Right?

Wrong! But that's no more preposterous than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more exacting. In fact, there are at least nine *specific differences* involving moisture content, purity, potency and speed of tablet disintegration, which make the manufacture of Bayer® Aspirin so different.

These Bayer standards result in significant product benefits, including gentleness to the stomach and product stability, that enable Bayer Aspirin tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that *all* aspirin tablets are alike, you can say, with confidence, that "it just isn't so."

You might also say that all otolaryngologists aren't alike, either.



(Continued from Page 684)
graduate medical education at the same institution. Indeed many select internships on the assumption that they will be given priority when subsequently applying for residency training there. Certainly most educators would not criticize this motivation. Yet there are advantages in doing the internship and residency at different hospitals for reasons discussed previously—different ideas, concepts of diagnosis and therapy, exposure to different "experts," etc. Some individuals advocate splitting their residency training between two or three different institutions for these same reasons.

E. *Geographic Location, Personal and Family Situation.* Because the process of acquiring a medical education has become so lengthy, the training physician should realize early that "school" is a way of life. The best years of his life are spent in acquiring the required knowledge. He and his wife are in the prime of their reproductive life, and many will want to start families while in training programs. It is unthinkable that the student would fail to consider his family's welfare and happiness when weighing the pros and cons concerning graduate medical education. One's wife is liable to have strong feelings concerning the location of the hospital both within the U. S. A. and within a particular city. These must be considered in the interest of family harmony.

Such factors as recreational facilities, climate, art, music, and theater activities will exert some influence when one considers living in the area 4-5 years. This represents a significant fraction of one's lifetime, and it should be lived in a manner compatible with one's personal goals and philosophy of life.

F. *Salary and Fringe Benefits.* It is doubtful that anyone can justify choosing an internship solely on the basis of financial rewards. Certainly finances preoccupy most medical students' minds, but with good borrowing power, if required, one is able to successfully supplement his year's intern stipend. One should not sacrifice a good year's training for $2000-4000. Certainly, were the choice between two equally good internships, almost everyone would advise the one offering the greater stipend.

G. *Working Hours.* This represents an area of immense concern to the average medical student. Being human, he desires some time to spend as he well pleases. He desires time for reading journals and reviewing appropriate basic medical sciences.

Most students, interns, and residents agree that it is largely through contact with patients, followed by reading with a purpose, that the text or journal material takes on real meaning and becomes firmly entrenched in one's repertory of medical knowledge. Without exception, the number of patients cared for by the intern increases with the number of hours on the wards; if sufficient time is available for reading concerning these patients' problems, (and provided the intern is not physically and mentally exhausted constantly) the "trainee" will acquire more knowledge than one who sees fewer patients. Most medical students contend that working every third night is tremendously more appealing, allowing him time and "gusto" to read some of his nights off.

III. *Retrospective Evaluation of Internships.*

The Council on Medical Education of the American Medical Association studied the internship year extensively and published their classic document in 1953, a copy of which may be found in the February 7, 1953 JAMA. Among other findings they listed the ten most common parameters on which the senior student based his choice of an internship. These included in order of importance:

1. Reputation of the hospital and internship.
2. Affiliation with a medical school.
3. Intended practicing in the community.
4. To secure a residency appointment.

5. Desire for association with staff members.
6. Stipend.
7. Hospital's research activity.
8. Not affiliated with a medical school.
9. Planned federal service career.
10. Various other reasons.

The most common causes for dissatisfaction with the internship in order of frequency were:

1. Lack of supervision.
2. Heavy patient load.
3. Program lacking.
4. Lack of responsibility.
5. Few teaching exercises.
6. Excess lab work.
7. Excess number of private patients.
8. Too many attending men.
9. Rapid rotation through services.
10. Routine duties.

One may benefit from thoughtful consideration of these facts. They do represent opinions of thousands of ex-interns; if one fails to be cognizant of history, it is bound to repeat itself.

Best of luck in your search!

FOOTNOTES

1. Millis' Report, GP 34:173, December, 1966, 35:199, January, February, 1966.

2. Directory of Approved Internships and Residencies 1967-68, pp. 123-33.

3. Nunemaker, John C., University of Michigan Medical Center Journal, 30:50-6, March-April, 1964.

4. Levit, et al., JAMA, 189:299, July 27, 1964.

5. Council on Medical Education, American Medical Association, JAMA, February 7, 1953.

Infectious Disease Therapy Revolutionized

The therapy of infectious diseases has been revolutionized since the introduction of sulfanilamide therapy over 30 years ago. The life saving effects in such diseases as pneumococcus pneumonia, meningococcic meningitis, thyphoid fever, and scrub typhus are nothing short of miraculous to those of us who knew these diseases in the pre-antibiotic days.

The reduction of the period of treatment of syphilis from two years or more to one week is a dramatic example of the saving in time and taxpayers' money. Countless other examples can be cited.

However this revolution in therapy has brought with it its problems. Those connected with drug reactions, although important and potentially dangerous can be handled by caution on the part of the physician and by research pharmacologists, in attempting to remove the toxic elements from these agents.

The emergence of resistant strains of bacteria is a more serious complication. Resistance of the staphylococcus, the gonococcus, the meningococcus, and the parasites of malaria create a serious threat to our future welfare. Fortunately, investigators throughout the world are fully cognizant of these crises and heroic efforts are underway to meet them.

It is perhaps difficult to evaluate, at the present time, whether the investigators or the organisms are winning the race.

—The Journal of the Arkansas Medical Society



around the state

New Physicians Licensed To Practice In Alabama



Belle Sumter Miller Carmichael, M. D., Cornell University Medical College, 1964, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.



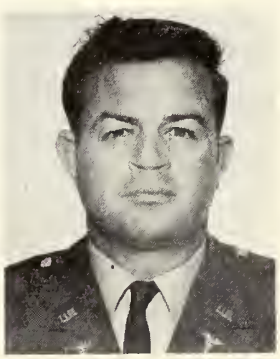
Harold Eugene Gebhart, M. D., Medical College of Alabama, 1968, Reciprocity with National Board of Medical Examiners—Location undecided.



Richard Michael Ehrlich, M. D., Cornell University Medical College, 1963, Reciprocity with National Board of Medical Examiners—Intends to locate in Montgomery (Maxwell AFB)



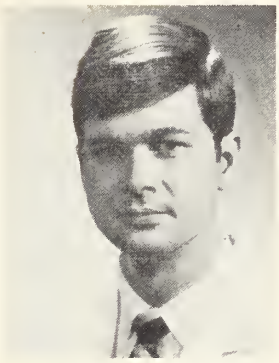
Michael Wayne Hakala, M. D., Medical College of Virginia, 1967, Reciprocity with Virginia—Intends to locate in Lanett.



Leo Michael Flynn, III, M. D., University of Florida College of Medicine, 1964, Reciprocity with National Board of Medical Examiners—Intends to locate in Phenix City or Mobile (Presently serving in U. S. Army at Fort Benning)



Charles Earl Jones, M. D., University of Iowa College of Medicine, 1964, Reciprocity with Iowa—Intends to locate in Birmingham.



Gillis Lavelle Payne, Jr., M. D., Medical College of Alabama, 1968, Reciprocity with National Board of Medical Examiners—Intends to locate in Bessemer.



Armand Eugene Zilioli, M. D., University of Miami School of Medicine, 1968, Reciprocity with National Board of Medical Examiners—Intends to locate in Ozark (Fort Rucker) .



Harvey Stuart Schuster, M. D., New York University School of Medicine, 1964, Reciprocity with National Board of Medical Examiners—Intends to locate in Montgomery (Maxwell AFB).



Chester Robert Smialowicz, M. D., St. Louis University School of Medicine, 1967, Reciprocity with Missouri—Intends to locate in Ozark-Dothan area, Ft. Rucker).



Jack Tipton Snapp, M. D., University of Tennessee College of Medicine, 1960, Reciprocity with Mississippi—Intends to locate in Huntsville.

Vital Statistics

NEW MEMBERS

Baldwin County

Hamilton, Longstreet Cavett, b 19, mc Tulane 44, recip Mississippi 69, P. O. Box 197, Fairhope, Alabama 36532 R.

Mobile County

Behlen, Charles Henry, II, b 37, mc University of Virginia 63, recip Virginia 69, 1653 Springhill Avenue, Mobile, Alabama 36604 D.

Carrington, Stewart Godbey, b 33, mc LSU 57, recip Louisiana 68, 1653 Springhill Avenue, Mobile, Alabama 36604 D.

Fraser, Swepson Floyd, Jr., b 36, mc Tulane 62, recip Louisiana 69, 1720 Springhill Avenue, Mobile, Alabama 36604 ALR.

Hightower, Billy Marks, b 26, mc Tennessee 55, recip Tennessee 69, 2451 Fillingim Street, Mobile, Alabama 36617 S.

Mosley, Billy Ray, b 37, mc Alabama 62, NBME 64, 1720 Center Street, Mobile, Alabama 36604 U.

Rencher, Daniel Mitchell, III, b 35, mc Tulane 60, recip Louisiana 69, 1563 Springhill Avenue, Mobile, Alabama 36604 Oph.

Snodgrass, Phillip Alvin, b 38, mc University of Arkansas 64, recip Arkansas 65, 2451 Fillingim Street, Mobile, Alabama 36617 Resident.

Stamm, James Edward, b 37, mc Indiana 64, recip Indiana 69, 1557 Springhill Avenue, Mobile, Alabama 36604 ObG.

Wingard, Christian, b 24, mc Alabama 46, sb 48, 2100 Freemont Drive, Mobile, Alabama 36609 (transfer from nonmember Mobile County to member Mobile County) PH

DEATHS

Jefferson County

Martin, William Bertram, 2316 Country Club Place, Birmingham, Alabama—deceased October 26, 1969

Mobile County

Hannon, William Campbell, 1600 Center Street, Mobile, Alabama—Deceased December 1, 1969.

Talladega County

Craddock, French Hood, Sylacauga, Alabama Deceased October 23, 1969.

CHANGE OF ADDRESS OF MEMBERS

Baldwin County

Gessler, William Francis, present Fairhope to 402 Boone Lane, Fairhope, Alabama 36532

Russell, Robert Burke, present Spanish Fort to P. O. Box 1030, Foley, Alabama 36535

Calhoun County

Woodruff, Gerald Ginness, Jr., present Anniston to 1415 Christine Avenue, Apt. 8, Anniston, Alabama 36201

Chambers County

Cowles, William Lee, present Lanett to P. O. Box 468, West Point, Georgia 31833

Colbert County

Williams, Roy Winston, present Sheffield to 907 Woodward Avenue, Muscle Shoals, Alabama

Cullman County

Whiteside, Maurice Scarbrough, present Cullman to 2316 North Tucson Blvd., Tucson, Arizona 85716

Dallas County

Williams, Jonathan Richard, present Selma to 106 Winthrop Court, Selma, Alabama 36701

Houston County

Atkinson, Gordon Allen, present Dothan to 1912 Fairview Avenue, Dothan, Alabama 36301

Jones, Samuel Hovey, Jr., present Dothan to 1912 Fairview Avenue, Dothan Alabama 36301

Jackson County

Gibson, Thomas Ashford, present Scottsboro to P. O. Box 927, Scottsboro, Alabama 35768

Jefferson County

Collier, James Benton, present Birmingham to 10 Crestview Circle, Birmingham, Alabama 35213

Hazelrig, Cooper Green, present Birmingham to 1230 South 19th Street, Birmingham, Alabama 35205

Langley, John Olin, present Birmingham to 1720 Center Street, Mobile, Alabama 36604

LeMay, Bobby Paul, present Birmingham to 924 South 19th Street, Birmingham, Alabama 35205

McElroy, James Bernard, present Birmingham to 1211 27th Place, South, Birmingham, Alabama 35205

Mitchell, Sidney Ashley, present Birmingham to 1418 Stouts Road, Birmingham, Alabama 35205

Rosser, Robert George, present Birmingham to Medical Arts Building, Birmingham, Alabama 35205

Lauderdale County

Zickler, James Brown, present Florence to Route 2, Killen, Alabama 35645

Madison County

Robinson, Paul Alvin, present Huntsville to 201 B Longwood Drive, S. E., Huntsville, Alabama 35801

Mobile County

Bodet, C. Adrien, present Mobile to 1720 Center Street, Mobile, Alabama 36604

Kahn, Leon, present Mobile to 1720 Springhill Avenue, Suite 414, Mobile, Alabama 36604

Walker, Howard S. J., present Mobile to 124 Williams Court, Mobile, Alabama 36606

Montgomery County

Alphin, Thomas Henry, present Montgomery to 304 Dexter Avenue, Montgomery, Alabama 36104

Tuscaloosa County

Partlow, Rufus C., present Tuscaloosa to Box 3155, Tuscaloosa, Alabama 35401

White, Roy Sidney, present Tuscaloosa to 1314 Montclair Circle, Tuscaloosa, Alabama 35401

Walker County

Snow, William R., present Jasper to Route 8, Box 335, Jasper Alabama 35501

Morgan County

Pack, Milton, present Decatur to 1202 13th Avenue S. E., Decatur, Alabama 35601

Royer, William A., present Decatur to 811 Second Avenue S. E., Decatur, Alabama 35601

CHANGE OF SPECIALTIES

Colbert County

Blue, Foy E., 905 Woodward Avenue, Muscle Shoals, Alabama 35662—Surgery

Syslo, Joseph A., P. O. Box 191, Sheffield, Alabama 35661—Industrial Practice—Urology

NEW TELEPHONE NUMBERS

Alphin, T. H., Montgomery	269-7596
Behlen, Charles H., II, Mobile	433-1661
Hamilton, L. C., Fairhope	928-5636
Hightower, Billy, Mobile	473-0341
Kahn, Leon, Mobile	438-2474
Klinner, K. V. Jr., Opelika	745-7098
Langley, John, Mobile	433-1506
Mann, M. B., Montgomery	264-5362
McElroy, James B., Birmingham	328-2457
Mosley, Billy R., Mobile	433-6595
Murdock, Church, Mobile	433-8463
Rencher, Daniel M. III, Mobile	433-7469
Russell, Robert B., Foley	943-8051
Snodgrass, Phillip A., Mobile	473-0341
Stamm, James Edward, Mobile	432-9701
Wingard, Christian, Mobile	432-1631
Fraser, Swepson F. Jr., Mobile	433-2564

Not just a motel
it's a Guest House

. . . with 171 handsome rooms designed for your comfort and convenience. A center-of-everything location including Birmingham's University of Alabama Medical Center . . . making The Guest House a favorite of Doctor's wives and in-town outpatients. Superb dining, dancing and nightly entertainment. Come stay with us often.

THE RESTAURANT
THE PLAYROOM • CYPRESS ROOM
CONVENTION FACILITIES



The Guest House
MOTOR INN

PHONE 324-8653
18TH ST. &
10TH AVE., SOUTH
BIRMINGHAM, ALABAMA

"Where the Action Is!"

Hobbies To Fill A Doctor's Leisure

The Merits And Mysteries Of A Camera

by William A. Daniel, Jr., M. D.

Professor of Pediatrics

University of Alabama in Birmingham

Few of us select photography as a hobby because we wish to study optics or to review our forgotten chemistry—we do it to make pictures. Most of my photographs are records of where I have been, of our family, important events or interesting medical conditions. But, there are some photographs which provide me with an esthetic enjoyment: they express a feeling that is, at least to me, beautiful.



Dr. Daniel

The photograph of the mother and little boy was taken in Guatemala, and I have a very large print hanging on a wall in our home. The boy's ragged pants, the obvious symbols of poverty coupled with the patience of his mother remind me how happy he seemed as he played in the market place. It has been said that the evidences of prosperity—wealth, leisure and power—are not an answer to the afflictions of adversity but constitute a problem in themselves for man has not learned to cope with them after he has produced them. It is helpful to remember that money does not always bring happiness and this picture constantly reminds me of this axiom.

The other photograph was taken in an underdeveloped country. The original is in color and has much more impact than this reproduction. Starvation is present in most



of the world and this print reminds me not only of the great needs of the world but brings a little humility to me, reminding me to be grateful for what I have. There is no large photograph of this marasmic child hanging on my wall but the little girl cannot be forgotten.

Like most of us, the majority of my photographs are in color and the beautiful scenes, the smooth delicate skin of one's grandchild, or even the unusual medical conditions are of interest but cannot be reproduced here in color.

Photography is an excellent hobby because it permits anyone to pursue it to the degree



of satisfaction that he desires. Many physicians want only to record aspects of a trip and an Instamatic camera is all that is required to achieve this objective. Others become fascinated with equipment, buy very expensive cameras and accessories and may take very few pictures, many of which are no better than those produced by the simple camera. But, real "photo bugs" use many of the laws of physics that we learned and forgot many years ago but which, when used, produce consistently excellent results. For example, the intensity of light produced by a flash bulb or electronic device follows the law which says that output varies inversely as the square of the distance. This may sound complicated but in use the principle is applied to insure correct exposure. Other physical laws govern close-up photography, available light pictures, telephoto exposure etc. Chemistry is also used if one processes his own films or makes enlarged prints. Various developers produce different results and temperature of solutions is related to density of the negatives. Thus one may become interested in these aspects of photography if he wishes; or, he may merely use the conclusions of such laws to produce consistent work.

Most doctors are fascinated by precision equipment whether it is a new shotgun, a new set of golf clubs, a rod and reel or a camera. It is often said that photography is an expensive hobby; it would be more accurate to say that it can be. I once was trying to put together a hi-fi stereo set and the question of speakers arose because of the wide range of prices. One of my ENT colleagues suggested that at my age it would be foolish to buy certain types because I was not capable of hearing high frequencies—I was a bit over 30 at the time!—and the dog, who could hear them, didn't give a damn anyway. It is the same with cameras and accessories—why buy the most expensive model unless you plan to really take the time to learn to use it correctly? Too often I have seen colleagues buy a very expensive new camera a few days before a trip, never bother to read the instruction booklet, and take off for Europe not knowing whether it worked, only to be disappointed in the results.

Collectors of stamps, coins or even vintage cars have nothing on the photographic collector. One may, if he chooses, collect cameras of various categories or all within one famous brand. Searching and swapping for certain model cameras and putting them in mint condition is just as interesting as the gun collector who limits his acquisitions, for example, to Lugers. Guns and cameras should be in perfect working order. Many doctors have excellent equipment which they use two or three times a year and then wonder why there may be a malfunction. Mechanical apparatus of any kind needs exercise to function perfectly and a camera left on the shelf is destined for trouble. If you have a good camera, at least run through all the shutter speeds every couple weeks just to keep the juices jangling.

Few hobbies are pursued on a rational basis and although reason would help financially I am not convinced that one would enjoy it more. Even so, the newcomer to any

hobby may often save money by seeking expert advice regarding purchases until he is capable of deciding for himself. In photography, camera models vary as to purpose, size, cost, available accessories and it is financially hazardous to rush in and buy equipment without knowing what one really needs. Any hobbyist is glad to help another whether he is a rockhound, a fisherman, ham radio operator or a photographer. To end, let me wish you real and continued enjoyment in photography and should you need information about cameras or photography, I will be glad to help if I can.

Recall Of Contaminated Catheters Urged

On December 3, the Commissioner of the Food and Drug Administration sent the following telegram to the County Medical Societies and to the State Health Departments:

"This is to bring to the attention of your membership an urgent health hazard involving 49 types of sterile urethral catheter trays and kits produced by C. R. Bard, Inc., Murray Hill, N. J. All these trays contain a packet of cleansing solution or 'Detergicide.' This 'Detergicide,' also called 'Prep Solution,' 'Cleansing Solution,' or 'Antiseptic Towlette,' has been found to contain bacteria of pseudomonas species, commonly known as EO-1, a pathogenic organism which may produce severe genito-urinary infections.

"C. R. Bard, Inc., undertook a voluntary recall in September of the contaminated trays from its distributors and from hosiptals in the United States and Canada. FDA has determined that the recall was not effective due in part to lack of cooperation by several large distributors who declined to participate.

"FDA attempted to warn nursing homes and the medical profession of the dangers involved in the use of these trays by issuing a press release on October 20, 1969.

"FDA checks on dissemination of the warning have revealed, however, that the majority of nursing and convalescent homes are still unaware of the recall or the health hazards of the catheter trays containing the contaminated detergicide. We have found them still in use.

"Within the last few days a marked increase in severe genito-urinary infections associated with the use of the catheter trays containing the contaminated detergicide has been reported by hospital authorities.

"Additional investigations by the FDA have also disclosed non-sterility of some of the lubricant jelly packs in the Bard trays. In view of the gravity of this situation and the patient-hazard involved, we have discussed this matter with the AMA. We urge your assistance in alerting all physicians associated with hospitals, urologic clinics, nursing and convalescent homes, to take immediate steps to check all stocks of sterile urethral catheter trays or kits from C. R. Bard, Inc., and arrange for prompt return to the supplier of any existing stocks bearing any of the re-order or item numbers listed below:

7501	8300	8465-18	8560
7503	8364-16	8500	8810
7505	8364-18	8501	8816
7602	8365-16	8504-16	8816-A
7602P	8365-18	8504-18	8818
7604	8400	8505-16	8818A
7610	8401	8505-18	8819
8145	8464-16	8505A-16	4200
8214	8464-18	8505A-18	4210
8216	8465-16	8554	8556-A
8218		8556	
8220		8554-A	8560-A

8464-D-18 and 8464D-18 are subject to recall No. 363-0."

The Alabama Department of Public Health is cooperating with the FDA in contacting all licensed health facilities in the state to apprise them of the health hazard and recall of these catheter trays and kits.

Fathers and Sons in Medicine

The Arthur F. Tooles II and III, M. D., Of Talladega

Like father, like son?

Long before this effective piece of anti-smoking propaganda first appeared on the television screen, long before Columbus returned to Europe with the first dried leaves of the Indian weed, sons were following in their fathers' footsteps in all kinds of careers, including medicine.

"A chip off the old block" was a compliment to both fathers and sons.

Three and a half months before the Japanese struck by air and sea at Pearl Harbor, on August 7th, 1941, a son was born to a general practitioner in Talladega, and named Arthur Fulkerson Toole III.

Today the father, one of 33 members of MASA in Talladega County, is treasurer of the Talladega County Medical Society, while the son, after concluding his military service, including a year in Vietnam, is in general residency at Charlotte Memorial Hospital.

Arthur F. Toole, the second of that name, was born in Birmingham July 1, 1911, spent his childhood in Asheville, N. C., earned his baccalaureate degree from the University of North Carolina, and his degree in medicine from Harvard in 1935. Post graduate training was in Presbyterian Hospital, Philadelphia. Mrs. Toole is the former Barbara Reagan of Chicago and they have three children. The Tooles moved to Talladega 30 years ago last year.

The son received his undergraduate training at Davidson College and his M. D. at the University of Alabama Medical School in Birmingham in 1966. After a year's internship in Philadelphia General Hospital, he entered the army, became a flight surgeon, and



Drs. A. F. Toole II and III

was attached to the 9th Infantry Division in Vietnam. Last August 2nd, two days before his separation from service, he was married to Judy Davis of Orangeburg, S. C.

Automobiles Don't Blend Well

Observed Evarts Ambrose Graham, M. D., the famous surgeon:—"Until homo sapiens becomes more sapient I can see no prospect of his ever avoiding the foolishness of war or of his learning that two automobiles cannot occupy the same spot at the same time, especially when they come from opposite directions. Broken bones and lacerated wounds are therefore likely to require surgical attention for as long as this would-be clairvoyant can see into the future."

—*Journal of the Georgia Medical Association*

States Of Alabama And Florida Divide Alisons' Allegiance

Two sons were born of the marriage of the James Fairly Alisons and, as if to equate the sites of their nativity, one of the two was born in Palm Beach County, Florida, the other in Dallas County, Alabama.

Mrs. Alison (the former Olivia Evans) is a native of Palm Beach County, and Dr. Alison of Dallas County.

James F. Alison was born on the last day of the first year of the 20th century, attended the University of Alabama, earned his M. D. at Tulane, and began the practice of medicine in Selma when he was 27 and his first-born, James Fairly Alison, Jr., was less than a year old. A Fellow of the American College of Physicians (1932), certified to the Board of Internal Medicine (1937), he lists his hobbies as hunting, fishing and boating, in between the practice of medicine in Selma and the supervision of his plantation, with its herd of Charbray cattle.

James F., Jr., was born at Delray Beach, Fla., just two years before the Stock Market (like Humpty Dumpty) started teetering on the wall (Wall Street, that is) Oct. 3, 1927. Like his father, Alabama and Tulane respectively are his alma maters. His military service was spent in Fairbanks, Alaska (1953-55). He has practiced medicine in Selma since 1956, certified to the Board of Pediatrics in 1957, and a Fellow of the American Academy of Pediatrics since 1958.

The junior Dr. Alison is married to the former Celia Sheptrine, of Selma. They have two daughters, Fontaine and Olivia, and a son, James Fairly Alison III. Hunting, fishing and golf are listed as Dr. Alison's hobbies.

Our economic Humpty Dumpty had just begun to piece itself together again when William Evans Alison was born in Selma June 1, 1933. Like his father and his older brother, he went through Alabama and Tulane to an M. D. degree (1958). And like his brother, his military service was as an Air Force Captain (1959-61). But from there on his path separated from that of the other two. His practice turned to specialization in Obstetrics and Gynecology and he moved to Huntsville with his family—which consisted of his wife, the former Cecilia Diffly of Selma, and their three sons: Lee, now 15, Jim, and Bill.



J. F. Alison and Sons, all M. D.'s

Dr. W. Evans Alison, a Diplomate of the American Board of Obstetrics and Gynecology (1967) and a Fellow of the American College of Obstetrics and Gynecology (1968), lists golf and horses as his hobbies.

Adolescents Hate Hypocrisy

"To combat drug abuse among adolescents," suggests a release from the American Academy of Pediatrics, "factual material about drugs commonly used by young people should honestly be presented, and a suitable environment should be created to relieve school and family pressures and help youngsters find better challenges."

Suggesting that the approach to the parents may be delayed, so that the adolescent may be encouraged to agree to the parents' envolvement, the piece warns that "teenagers consider hypocrisy the greatest sin and frankness is exalted."



The Bradley Center --- for the problems of living

An all new homelike open psychiatric residence on a lovely five-acre tract, centrally located within the community, providing a comprehensive range of continuous services, including in-patient, day care, and outpatient treatment. Each patient participates in an extensive and intensive treatment program, based almost exclusively upon multiple psychotherapeutic encounters. These include individual psychotherapy, group psychotherapy, the nursing milieu, occupational therapy, recreational therapy, topical small group discussions, and other group activities in the Center, as well as in the community, depending on individual needs and interests. Medications are prescribed when appropriate.

Any individual may be admitted who, in the opinion of the medical staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible family member.

Accredited by the Joint Commission on Accreditation of Hospitals.

Leonard T. Maholick, M. D.
Medical Director

Maj. Gen. (ret.) Howard Snyder
Administrator

THE BRADLEY CENTER, INC.
2000 Sixteenth Avenue
Columbus, Georgia 31901
Area Code 404 324-4882

Three Becks, M. D., in Practice In Alabama

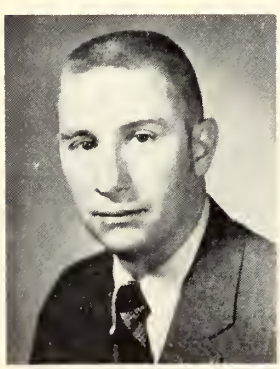
A native Georgian who graduated in medicine in Tennessee who, except for war service has been in General Practice in Alabama since 1936 is the father of two other doctors, one now practicing in Alabama, the other interning in an Alabama hospital.



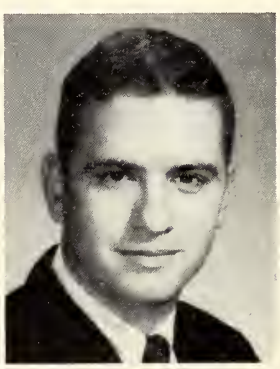
Chester K. Beck

Chester Keith Beck was born in Dupont, Ga., July 23, 1909, the son of a railroader. Three months later his family moved to Troy, Ala., where he is today president of the Pike County Medical Society.

The span of time between the age of three months and 60 years plus six months has included education through the public schools of Troy, following two older brothers through courses at Auburn University (classes including the School of Pharmacy, the School of Veterinary Medicine, Agriculture and Engineering), and an M. D. degree from the University of Tennessee; interning at Baptist Memorial in Memphis; his marriage to the former Frances LeMay; General Practice with Dr. O. N. Edge in Troy for 4½ years, beginning April 1, 1936; service in the Medical Corps, in which he rose from lieutenant to lieutenant colonel, including the Base Hospital, Camp Stewart, Ga.; school in gastroenterology at the Army and Navy Hospital, Hot Springs, Ark.; organization of the 16th General Dispensary (consisting of nine medical officers and 36 technicians) which he led from Camp Barkley, Texas, to Calcutta, India; returning to solo practice in Troy in March, 1946, where he has continued ever since.



Ronald V. Beck



Jere L. Beck

Ronald V. Beck was born in Troy Dec. 16, 1939. He finished in the public schools of Troy and received his baccalaureate from Troy University in 1961. The Kilpatrick Trophy, awarded annually to an outstanding athlete with a high scholastic record and hitherto the exclusive recognition of football and basketball stars, went to Ronald Beck for his distinction on the track, where his half-mile speed set a record that stood until 1968.

Accepted by his father's alma mater, Tennessee, he elected instead to go to the University of Alabama Medical College. In his freshman year he met and married the former JoAnn Ware, who is today a medical technologist, and they have a four-year-old daughter and a two-year-old son. Dr. Beck interned at Lloyd Noland Hospital, and took his residency there also, specializing in OB-GYN. While chief resident, he won an essay contest sponsored by the Alabama Chapter, American College of Surgeons, and read his paper on "Choriocarcinoma" before that body last February. He has been practicing his specialty in Phenix City since last July.

Jere LeMay Beck, like his father, is a native Georgian—born Oct. 27, 1943, at Richmond Hill, Ga., while his father was in service. He was two years old when the family returned to Troy, where he attended the public schools, earned his baccalaureate at Troy State, where, like his older brother he was selected for *Who's Who in American Colleges and Universities,* received a Certificate of Award for excellence in scholarly achievement in the field of Science; and received his M. D. degree last June from the Medical Col-

(Continued on Page 703)



symptoms of mixed anxiety-depression are rarely clear-cut...
but they are often a clear indication for

Mellaril®
(thioridazine)
25 mg. t.i.d.

effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

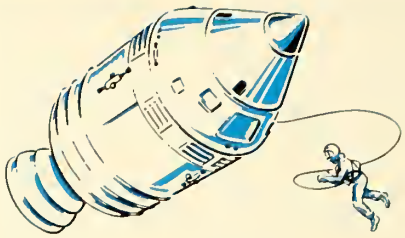
Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69-384



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals



Thera-Combex H-P®

This high-potency vitamin C and B-complex combination starts where diet stops

Kapseals®

Each Kapseal contains: ascorbic acid, 500 mg.; thiamine mononitrate, 25 mg.; riboflavin, 15 mg.; pyridoxine hydrochloride, 10 mg.; cyanocobalamin, 5 mcg.; niacinamide, 100 mg.; *dl*-panthenol, 20 mg.; Taka-Diastase® (Aspergillus oryzae enzymes), 2½ gr.



The Brown capsule with Green band is a Parke-Davis trademark.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

335R68

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind.

BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69

(Continued from Page 698)

lege of Alabama. Later in June he was married to Teresa Chastain of Gadsden, who had received her degree in nursing at the same time. Mrs. Beck is now with the University Hospital while her husband is interning at Lloyd Noland. He plans to specialize in OB-GYN.

These are two of three Beck sons. The eldest, Chester, Jr., born two days before Christmas, 1937, received his B. S. degree from Troy State, and is presently a chemist with American Cyanamid in Milton, Fla., pursuing his studies at night in Physical Chemistry. He is married to the former Shelia Sutton, and they have a two-year-old son, Chester Keith Beck III.

A Factor In MD Fees

Growing numbers of malpractice suits are causing major changes in U. S. medical care —increasing costs, changing the way many physicians practice, and forcing patients and physicians to view each other in a different light.

These are key conclusions of a Senate subcommittee report entitled "Medical Malpractice: Patient vs. Physician."

"The rising number of malpractice suits is forcing physicians to practice what they call defense medicine, viewing each patient as a potential malpractice claimant," says the report of the Senate Subcommittee on Executive Reorganization, headed by Sen. Abraham Ribicoff (D., Conn.).

—American Medical News

One 50-Year Club "Recruit" Golfs 54 Holes A Week

Half a century in medicine qualifies Willia Edward McGrath, M. D., for induction into the 50-Year Club of the Medical Association of the State of Alabama at the annual meeting in Mobile.



Dr. McGrath

Born in Hayneville, Lowndes County, Feb. 21, 1897, Dr. McGrath attended school in his native town until 1912, when he was enrolled at St. Bernard College, Cullman. He entered the University of Alabama School of Arts and Sciences in 1914. Alabama's Medical College two years later, received his baccalaureate in 1918, and his M. D. degree in 1920. He served his surgery internship at Providence Infirmary, Mobile, passed the State Board of Examiners, and began the practice of general medicine and surgery in Sheffield, associated with the late Dr. W. H. Greer.

After post-graduate work at Loyola University, he began OALR practice in 1923, and has continued practice in Sheffield since that time.

In 1921 Dr. McGrath and Miss Corrie Windham Cohen were married, and they have three daughters:—Martha Ann (Mrs. L. N. Brigham), Tacoma, Wash.; Corrie (Mrs. Frank Kaczmarek), Alexandria, Va.; and Florence (Mrs. Douglas W. Burnette), Falls Church, Va.

A member of the Colbert County Medical Society, of MASA and of AMA, the Sheffield Rotary Club, the Elks, Dr. McGrath helped organize the staff of Colbert County Hospital and served as its first Chief of Staff.

He also helped reorganize the Tennessee Valley Country Club, served as its first president, and was a member of its Board of Directors for a quarter of a century. Hunting and fishing are hobbies, but he is an inveterate golfer, playing 18 holes of golf three times a week—54 holes a week or 2,808 holes a year!



Development Of Areawide Comprehensive Health Planning Agencies In Alabama

Paul Kennedy

Assistant Director

Alabama Regional Medical Program

Background

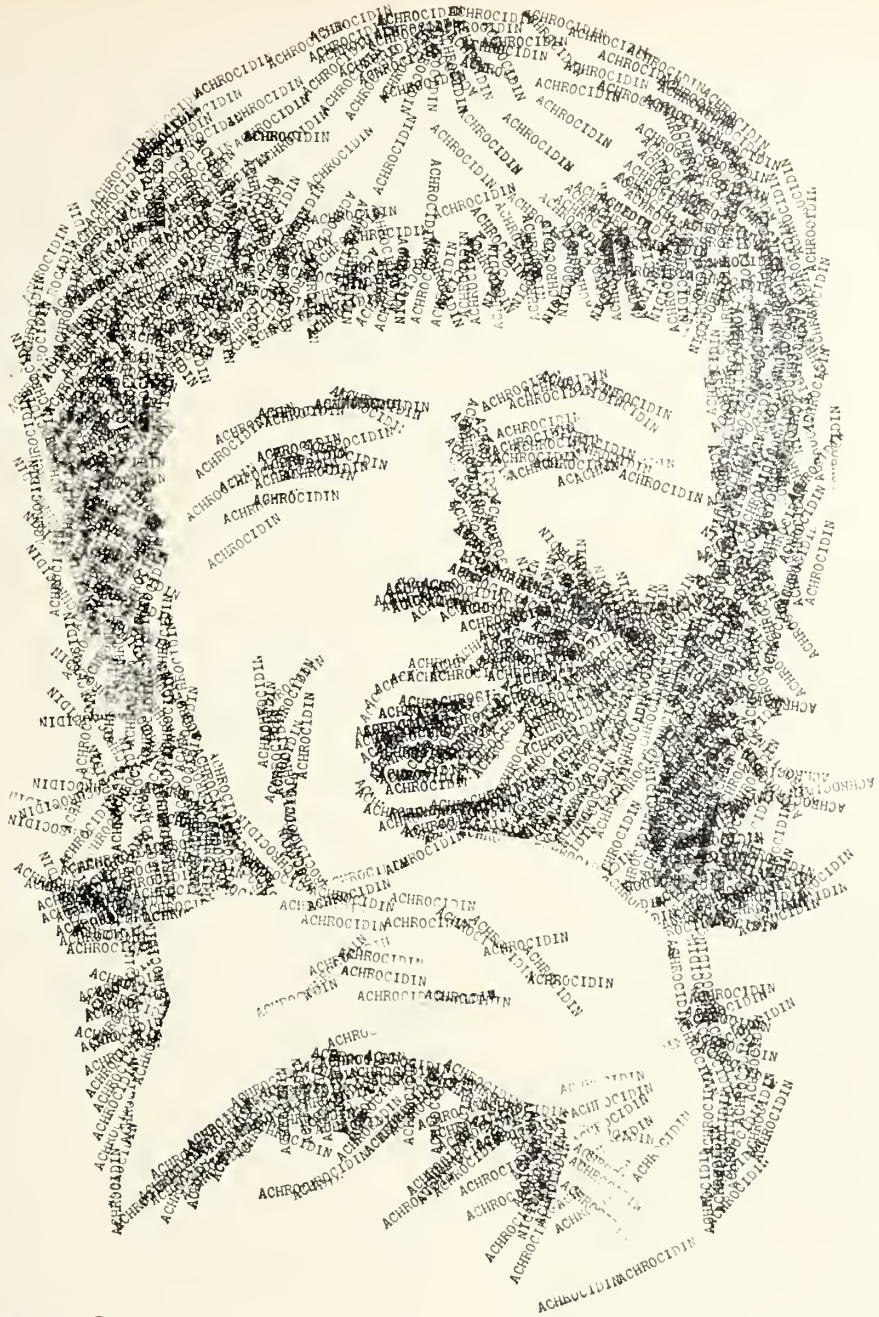
Planning is the process of defining a goal and the steps necessary to achieve it. This involves correlation of what exists to the practicality of what can be accomplished in a reasonable time span. Subsequently, planning becomes a real and viable tool utilized to produce a practical result. *Comprehensive* planning adds another dimension of measuring or encompassing or consolidating all concepts related to those elements necessary to bring about the desired result. This is true whether it concerns the subject of urban development, traffic patterns, or health and health related services. In our case, we are directly concerned with the latter terminology—comprehensive health services or health system. This encompasses financing, rehabilitation, environmental and personal health services, health education; diagnostic and treatment services, and medical and allied health manpower. These elements are complemented by the accessibility, availability, and acceptability of services to the consumer. The planning process itself generates ideas and concepts and must be responsive to the ever-changing demands of the consumer.

The comprehensive health planning process proceeds from a basis of detailed information about all health problems in a community. The process must be realistic and have a payoff, it must be goal oriented. Once facts are known, goals are then established and courses of action laid out to correct gaps and duplications and to deal with substandard services and facilities. The planning agency also has a monitoring function, and must periodically reevaluate goals and standards in the light of new knowledge and changing patterns and values.

Health Planning in Alabama

With the significant exception of the Hill-Burton program, which has long played an effective role in planning for health facilities,

(Continued on Page 706)



Achrocidin® Tablets and Syrup

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen Citrate 25 mg.

ACHROCIDIN Tetracycline HCl—Antihistamine—Analgesic Compound Tablets and Syrup are recommended for the treatment of tetracycline-sensitive bacterial infection which may complicate vasomotor rhinitis, sinusitis and other allergic diseases of the upper respiratory tract, and for the concomitant symptomatic relief of headache and nasal congestion. For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN Tetracycline equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Sensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

534-9

(Continued from Page 704)

Alabama has not experienced the development of health planning bodies common in the more urban industrial areas of the country.

In one respect we are fortunate that Alabama has not had a tradition of health planning agencies. We can set about building an ideal planning structure without compromise to the demands of existing agencies competing in the same arena.

The major effort in comprehensive health planning in Alabama began in 1967 when the Socio-Economics Committee of the Medical Association of the State of Alabama recommended the establishment of comprehensive health planning advisory committees throughout the state. This committee recognized that coordination of planning efforts should be initiated at the local and subregional level. Only at this level can accurate delineation be made of resources and needs since these assessments can best be evaluated by individuals who comprehend the mores and culture of their respective communities. Each community in each area of the state was seen as having the responsibility to evaluate its own needs, examine its own resources, and bring practical solutions to bear on its health problems.

In the two years since the MASA Socio-Economics Committee made its recommendations, medical advisory committees for health planning programs have been organized by nearly every county medical society in Alabama. Most significant has been the development of broad-based multi-county health planning councils throughout the state. Following is a list of the councils developed in each of the seven health planning areas established in the state.

Tennessee Valley Area

1. Appalachian Regional Commission (Lawrence, Morgan and Limestone Counties). Chairman of commission is Mr. Barrett Shelton and Mr. Dennis Opheim is staff director. Funded by Appalachia program.
2. Huntsville Health Planning Council (Madison County) with board of directors composed of half physicians, half hospital administrators. Mr. Millard Johnson is chairman, no staff.

Northeast Alabama Area

A health planning council is now being developed under the leadership of county medical societies in the area and the Northeast Alabama Hospital Council.

Central Alabama (Montgomery) Area

Montgomery Regional Medical Foundation (Montgomery County with adjacent counties now being added). President of the foundation board is Dr. William Reynolds and Mr. David Carter is staff director.

Southeast Alabama (Wiregrass) Area

CAPHWA (Council of Comprehensive Areawide Planning for Health Care in the Wiregrass Area) organized in July, 1969. Chairman of board is Mr. Dean Byrd, no staff.

Gulf Shores (Mobile) Area

State approved Areawide Comprehensive Health Planning Agency under Mobile County Board of Health which will eventually include surrounding rural counties. Agency is funded locally and its staff is directed by Mr. Vernon Knight under Council Chairman, Dr. Robert King.

West Alabama (Tuscaloosa) Area

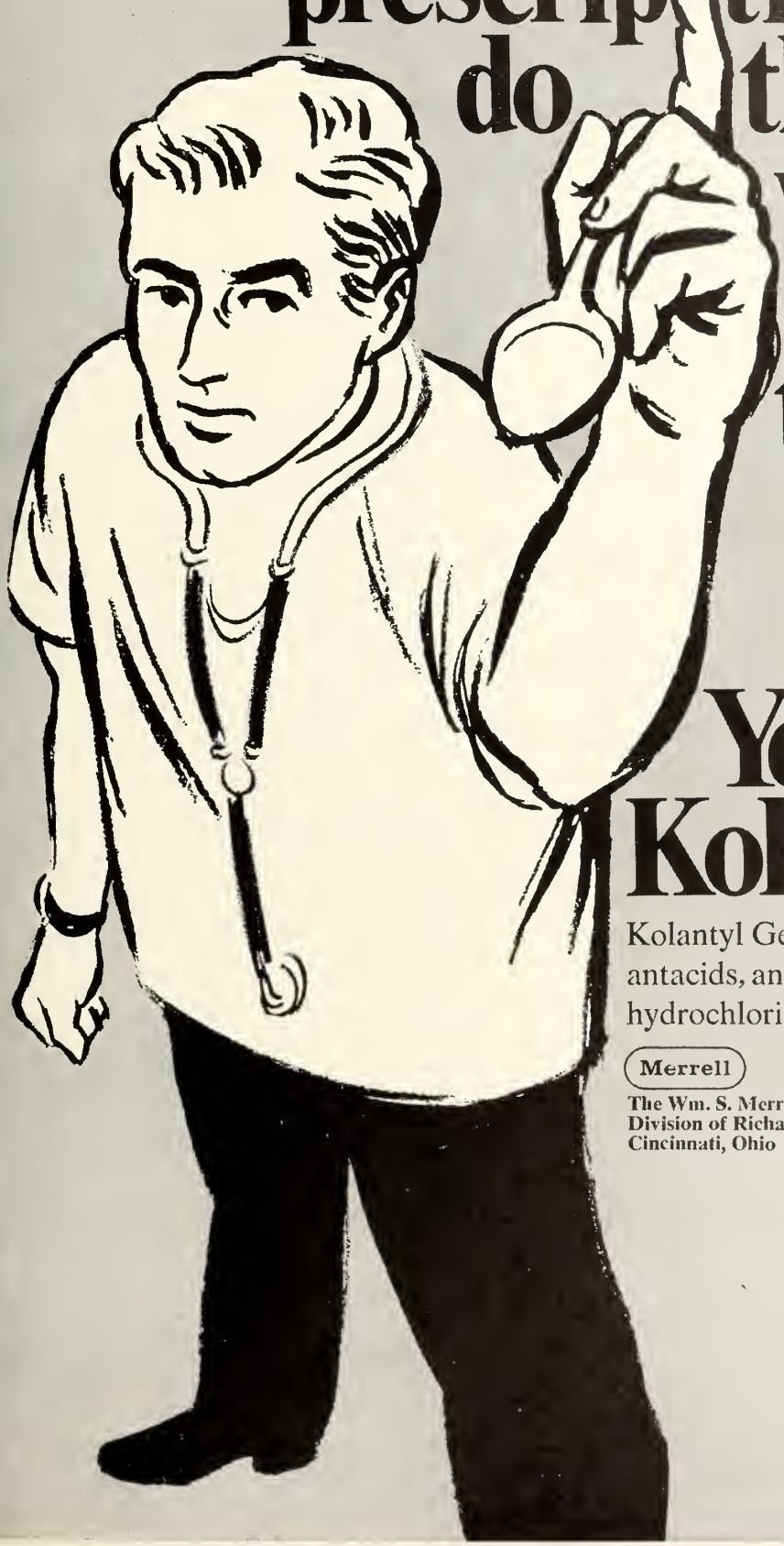
West Alabama Comprehensive Health Planning Council organized in May, 1969. Chairman of the council is Dr. Everett Hale, no staff.

North Central Alabama (Birmingham) Area

The Community Health Planning Commission, the only federally funded areawide

(Continued on Page 708)

Can one prescription do the work of two?



Yes, Kolantyl®.

Kolantyl Gel/Wafers contain antacids, and Bentyl® (dicyclomine hydrochloride) too.

Merrell

The Wm. S. Merrell Company
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215

(Continued from Page 706)

health planning agency in Alabama, was organized in January, 1968. The agency will eventually include all counties in the area. Chairman of the council is Mr. Robert Block and the director of the staff is Mr. George Rice.

Areawide Comprehensive Health Planning

Development of Agencies in Alabama

The most rational approach for the future development of areawide comprehensive health planning (AWCHP) agencies (as defined by Public Law 89-749) in Alabama is to build upon this structure of health planning councils. The development of these councils into bonafide AWCHP agencies should be viewed as a process occurring over a period of time, with the various councils starting at different points along a continuum. The Birmingham Area, for example, which has the only Federally funded AWCHP agency in Alabama, had a substantial background of planning experience as a result of having a health facilities planning agency, a regional planning commission, the University of Alabama in Birmingham, and a well established and staffed community service council. The Wiregrass Area in Southeast Alabama, on the other hand, has had little experience with formal planning agencies and is naturally developing at a slower pace.

It is recognized by all concerned that the attainment of AWCHP agency status must be earned by a health planning council, it cannot be merely awarded by official designation. U. S. Department of Health, Education and Welfare regulations state very simply the enormity of the task: "The applicant (for AWCHP agency) should be recognized by the major governmental units and public and voluntary agencies in the area as having the responsibility for conducting a comprehensive areawide health planning program, or for undertaking efforts to organize a comprehensive health planning program."

The process of transforming health planning councils into areawide comprehensive health planning agencies will be materially aided by "Guidelines for Establishing Areawide Comprehensive Health Planning Agencies" now being developed by the Alabama Comprehensive Health Planning Council. The nucleus for these guidelines will follow from the law itself and the recommendations of the Committee on Socio-Economics for the Medical Association of the State of Alabama as reported in the *Transactions of the 1968 Session of the Association.*

The Alabama Comprehensive Health Planning Council, in developing these guidelines, is also considering the recommendations of such competent organizations as the American Public Health Association and the national experience to date in the operation of Areawide Comprehensive Health Planning agencies as reported in the August, 1969 study by the Health Service Research Center, American Rehabilitation Foundation. Following is a summary of recommendations and comments from these sources on the most important aspects of establishing AWCHP agencies:

1. *Sponsoring Agency for Areawide Comprehensive Health Planning*

   Under Public Law 89-749, grants may be made to either public or private nonprofit organizations to establish an AWCHP agency. In the case of a private organization, there must be appropriate representation of the interests of local government.

   The American Public Health Association states there are many organizational options, some obviously better able to carry out certain functions while others may be more effective in other directions. APHA recommends that, because the selection of the "ideal" form for the planning body in a given community is difficult if not impossible, the task be approached through the establishment of a healthy assembly or an exploratory com-

mittee which would raise the issues of functions, attributes, subject scope, and boundaries and then design a structure best suited to meet the needs of the particular area.

The American Rehabilitation Association study of AWCHP agencies reported the following range in parent agencies from a survey of 63 agencies in July, 1969:

Parent Agency	No. of Agencies	Per cent
Health facility planning body	16	25
Health & Welfare Council or other community agency	10	16
Local government unit	11	16
—metropolitan/regional council or Council of Governments (COG's)	5	
—Economic Development Districts	4	
—City/County Health Departments	2	
Medical Society	2	3
None—agency newly constituted	24	40
Total	63	100

2. *Areawide Comprehensive Health Planning Council Structure*

The American Rehabilitation Study reports that AWCHP agencies considered the most important factor in their success was the participation, involvement and commitment of their "constituents." A number of key ingredients were: assuring fair and equitable representation (consumer - provider - demographic) on the council, developing meaningful roles for agencies desirous of being involved, commitment of local governmental units to results of AWCHP efforts, and consumer commitment to council direction.

The American Public Health Association recommends that: council members should be selected for their leadership qualities, rather than as representatives of categorical or organizational interests; that size of council should be kept to a minimum of forty members or less with the larger community being involved through committees and task forces; and that council members should be able to stimulate implementation of planning by influencing necessary political action and financing.

3. *Delineation of Area*

Area covered by one AWCHP agency should ideally consist of a natural planning area, a self-contained health service area that is quite useful for planning, but not the rigid breakdown into "base," "intermediate," and "rural" health care facilities. The medical service areas are more than a series of lines on a map enclosing a segment of the state population. An analysis has to be made of each area and its composition in order to specifically identify needs and resources available to meet these needs. Questions relative to the economic base of the area, the population at-risk, referral patterns, and time-distances involved in reaching health facilities must be asked and answered before the final determination of need is settled. Ideally, the coordination of health facilities and services and planning for all categories of facilities and services is done within each area. This new method should produce a comprehensive picture of what exists and what is needed in each area of the State.

This type of planning should maintain a reasonable balance among categories based on local needs and prevent unnecessary duplication and gaps in providing health services.

AWCHP agencies are obviously con-

(Continued on Page 712)

Convalescing . . . but still a long way to go. Anxiety can make it even longer.

Convalescence following medical or surgical procedures may be almost endless to an anxious patient. And, indeed, anxiety with some patients actually retards progress—for example, by inducing insomnia and reducing cooperation.

As physicians have found during nearly 15 years of widespread use, Equanil may be a beneficial part of aftercare. It helps relieve anxiety and tension, thus often aiding your primary therapy.

Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

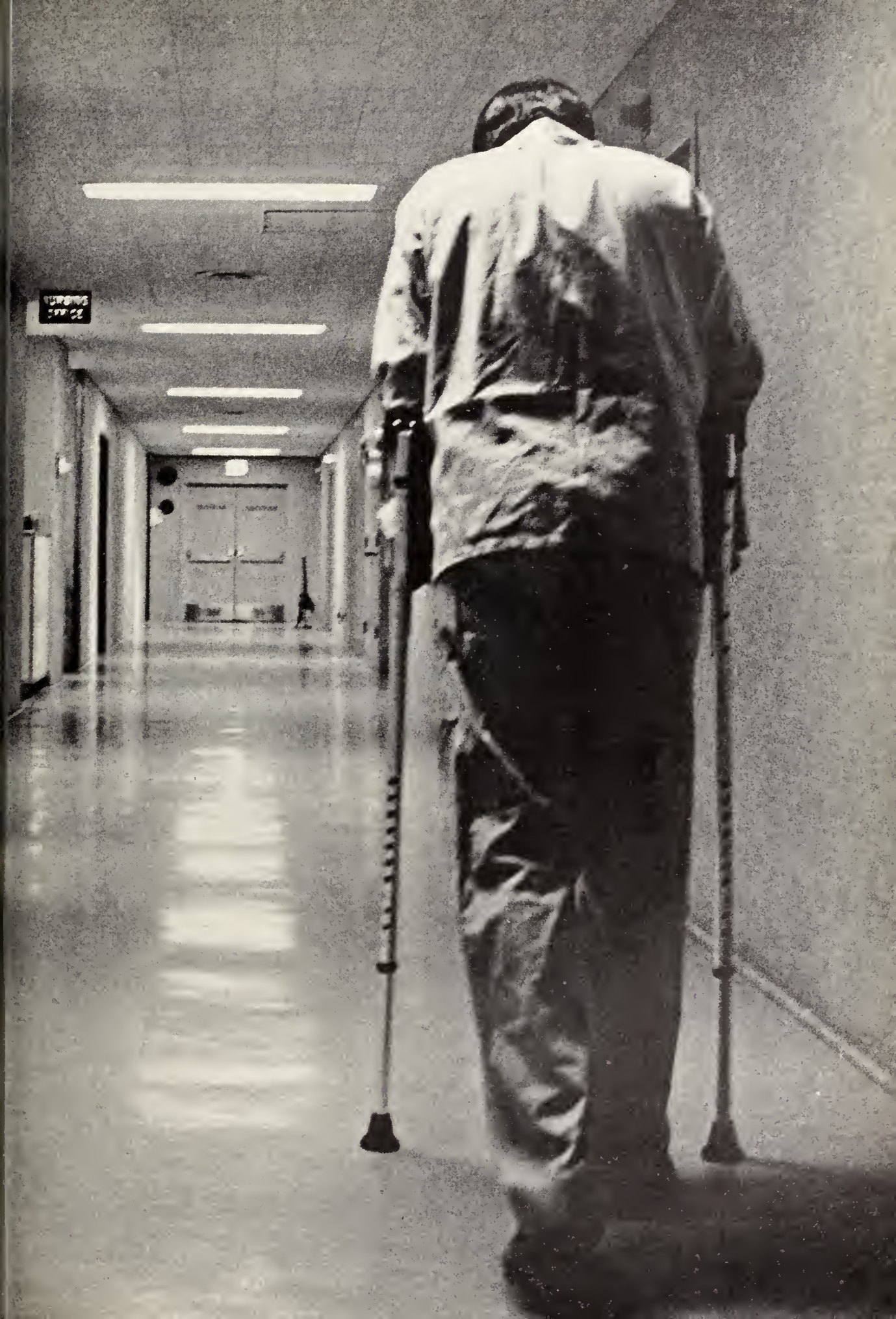
Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

EQUANIL®
(meprobamate)

Wyeth®

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.



(Continued from Page 709)

cerned with the total spectrum of health and must coordinate its work with that of economic, physical, social and other planning agencies in the area.

4. *Budget and Staff of AWCHP Agency*

The American Rehabilitation Association study reported the following potential sources for ongoing local funding from the 63 agencies surveyed.

Source	Number of Times Mentioned
Local government	38
Business and Industry	31
Health Care Institutions	28
Philanthropy (organized or individual)	28
Insurance Companies	25
Professional Organizations	15
Voluntary Agencies	12

The American Public Health Association recommends that the agency have full-time professional staff, although the agency may start with staff assigned from operating agencies but serving under its direction. APHA also recommends that local funds should, at least in part, come from other than agencies whose programs will be reviewed by the AWCHP; and that the AWCHP agency should be a nonprofit corporation, if not a public agency, to enable it to raise funds more easily.

5. *Legal/Administrative Support for AWCHP Agencies*

Some metropolitan areas of the country already require the approval by state designated AWCHP agencies over plans of voluntary health agencies and health care institutions within the area. Approval is particularly important in relation to construction or renovation of facilities and the provision of new services.

The five year health plan now under consideration by the Department of Health, Education and Welfare (plan formulated by Lewis Butler, Assistant Secretary for Planning and Evaluation—August, 1969) places major emphasis on AWCHP agencies for assurance of maximum effectiveness of federal funds supporting hospitals and nursing homes and for prevention of needless duplication of facilities and services. Specific mechanisms mentioned were that—

—Title 18 and 19 (Medicare and Medicaid) instead of being solely financial tools, would be used to encourage ambulatory and home care as alternatives to institutional treatment.

—Hill-Burton funds similarly would be used more for outpatient than inpatient facilities.

—The Nixon Administration plans to decentralize manpower training programs along with other proposals for revenue sharing and block grants will necessitate the development of new mechanisms at state and local levels. The AWCHP agency will certainly play an important role in such developments.

Where official and voluntary agencies and institutions have become committed to results of AWCHP agency efforts, an essential requirement has been that agencies must be aware of the standards or requirements by which their plans, fund requests, etc. will be measured. This is more difficult but absolutely necessary. If no standards (either formal or informal) are being used by the AWCHP agency, then this should be made known.

The American Public Health Association recommends that state legislation be obtained to provide a statutory basis for the operation of AWCHP agencies. The agencies' effectiveness would be enhanced

by legislative stipulation of matters on which it must be consulted.

The American Public Health Association also recommends that the State Comprehensive Health Planning Agencies encourage all private and public agencies and organizations to develop and submit their plans and recommendations on an annual basis to AWCHP agencies and that all proposals for funding, regardless of source of funds, be submitted to AWCHP agencies.

Recommendations from all sources are made to develop orientation, training and continuing education programs in comprehensive health planning for members of Comprehensive Health Planning councils and committees, staff, and representatives of provider and consumer organizations. Such education programs are now under development by the University of Alabama in Birmingham, in cooperation with the CHP agencies in Alabama.

Relationship of the Alabama Regional Medical Program to Comprehensive Health Planning

From its inception in 1967, the Alabama Regional Medical Program has been intimately involved with the comprehensive health planning program in the State. This close relationship between the two programs, unknown in many areas of the country, has assisted the people of Alabama in making the most effective use of sources of federal support for improving the organization and delivery of health services within the State. Maximum coordination and cooperation has been a primary goal of both programs.

The fact that both programs have served as catalytic agents is one of the most significant factors underlying the relationship. Neither CHP nor RMP replace any other organization's mission. Both programs are designed to encourage, not preempt, those who are engaged in health planning. Both programs provide a forum for the community to use in working together on health planning problems and strive to develop community approaches to community problems.

The close functional relationship between the two programs is exemplified by the recent decision of the Alabama RMP to request funds to staff the health planning councils and to assist their development into Areawide Comprehensive Health Planning Agencies. These councils will serve as the locus of RMP activities throughout the State. The concept of one health planning structure to serve both RMP and CHP is a prototype model which will be closely observed all over the country.

For Further Reading

Publications of the Health Services Research Center, Institute for Interdisciplinary Studies, American Rehabilitation Foundation, 1800 Chicago Avenue, Minneapolis, Minnesota 55404.

1. Comprehensive Health Planning in the State: a study and critical analysis, December 1968.

2. Reference Guide to Educational Opportunities in Health Planning, May, 1969; updated September, 1969.

3. Comprehensive Health Planning in the State: a current status report, July 1969.

4. From Organization to Operation . . . The Evolving Area-Wide Comprehensive Health Planning Scene, August 1969.

Holder, Lee and Deniston, O. Lynn, "A Decision Making Approach to Comprehensive Health Planning," Public Health Reports, Vol. 89, No. 7 (July, 1968), pp. 559-568.

Notes on Comprehensive Planning for Health, Henrik L. Blum and Associates, Western Regional Office, American Public Health Association, University of California, Berkeley.

The Urban Planner in Health Planning, American Society of Planing Officials, Public Health Service, U. S. Department of Health, Education and Welfare.

"Professional Competence Or Obsolescence--Which?"

Donald H. Williams, M. D.

"In all things let me be content,
In all but the great Science of my calling
Let the thought never arise
That I have attained to enough knowledge
But vouchsafe to me ever
The strength, the leisure and the eagerness
To add to what I know.
For Art is great,
And the mind of man ever growing."

—from The Physician's Daily Prayer
Maimonides 1135-1204 A. D.

A Good Doctor Never Graduates!

May I present Dr. Obsolescing Smith and Dr. Competent Smith? Both are qualified and registered to practice the healing art on the basis of existing legal requirements. Fifteen years ago both completed the first phase of their medical education and received their respective medical degrees. Dr. O. Smith graduated finally and irrevocably. With joyous abandon he severed, for good and all, the shackles of further learning and study. Now, 15 years later, his few medical books of graduation vintage remain unopened, gathering dust on display in his consulting room for his patients to observe and be duly impressed by their appearance of seeming weighty erudition. He subscribes to no medical journals. He attends no scientific medical meetings. He never enters a hospital to care for a patient; and to enroll in a postgraduate refresher course would never enter his head. The advances of modern medicine have long since passed him by and left him a beached, derelict hulk of professional obsolescence.

By contrast, Dr. C. Smith, the up-to-date, scholarly, compassionate, interested, available, unhurried, painstaking, competent doctor, has never really graduated. It is true that he enjoyed a memorable, pleasant, academic ceremony in the presence of the hierarchy of the university medical school establishment resplendent in their colorful robes, but for him that moment in time was just the beginning of the next phase of his medical education—the 40-year long continuum of scholarly, postgraduate endeavour in fulfillment of the deep sense of trust for his patients and their families which his exemplary medical school and its teachers had imprinted upon the conscience of his developing mind while under their care during his critical attitude-forming undergraduate days at the university.

To which Dr. Smith should a patient and family, burdened with illness, turn for care in their distress? Dr. Obsolescing Smith or Dr. Competent Smith?

Lifelong Scholarly Endeavor

The good doctor, the competent physician, is moved throughout life by a strong sense of scholarly trust and compassion to pursue, ceaselessly, the quest for new knowledge and new skills to the end that his trusting patients may be well cared for. This concept of lifelong learning is not new. Good physicians throughout the ages have been avid lifelong learners. Witness the plea of the great physician-rabbi-philosopher, Moses Maimonides, 800 years ago in his prayer for "the strength, the

(Continued on Page 716)

The Dixon Lecture was presented at Royal Victoria Hospital, Belfast, Northern Ireland, May 7th, 1969.

Dr. Williams is Director, Division of Continuing Education in the Health Sciences, Health Sciences Centre, The University of British Columbia, Vancouver, Canada.



Blue Shield's new URC program recognizes your "out-of-the-ordinary" charges through individual consideration by review committees composed of physicians.

BLUE CROSS-BLUE SHIELD OF ALABAMA



(Continued from Page 714)

leisure and the eagerness" to add to his fund of knowledge. Lord Lister[1] affirmed for his generation that "If you are not willing to learn and unlearn all your life through, you should give up medicine and take up a third-rate trade." William Henry Welch,[2] Osler's colleague and contemporary at Johns Hopkins University, restated the concept that "Medical education is not completed at the medical school: it is only begun."

Although this view is not new it has been given new impetus during recent years by growing dynamic forces of great complexity in our society. These forces are legion in number. For the hard-pressed, over-worked doctor they compound the problem of keeping abreast of the times. The provision of high quality health care today involves an increasingly intricate delivery-of-service mechanism; a Niagara of new medical knowledge pours forth; the expanding horizons of the biological, social and engineering sciences have an immediate relevance to the suffering of mankind; specialization at all levels of health care is the order of the day; new understanding of the teaching-learning process adds to the efficiency of study techniques and the adoption of innovation; and still that yawning canyon gapes, widely and deeply, between the new knowledge, skill and technology within our reach and its beneficent application for man's ills. In 1962 the President of the United States of America, the late John F. Kennedy, in addressing Congress[3] considered the matter of such national importance to government and the people that he placed on record his personal view that,

> "The accumulation of knowledge is of little avail if it is not brought within reach of those who can use it. Faster and more complete communication from scientist to scientist is needed, so that their research efforts reinforce and complement each other; from researcher to practising physician so that new knowledge can save lives as swiftly as possible; and from the health professions to the public so that people may act to protect their own health."

To the foregoing forces is added yet another—the growing public, professional and governmental concern about the competence of doctors. In 1967 the National Advisory Commission on Health Manpower suggested, in its report to President L. B. Johnson, that periodic re-examination and re-licensing may be the only way to insure "that a practitioner's knowledge reflects the most advanced results of medical progress." Commission member Dwight L. Wilbur, an internist and the president-elect of the American Medical Association, stated that, "Naturally, there will be resistance to licensing from doctors." However, Dr. Wilbur, for one, sees logic in the recommendation, pointing out that "What one learns in medical school is often not applicable ten years later." [4]

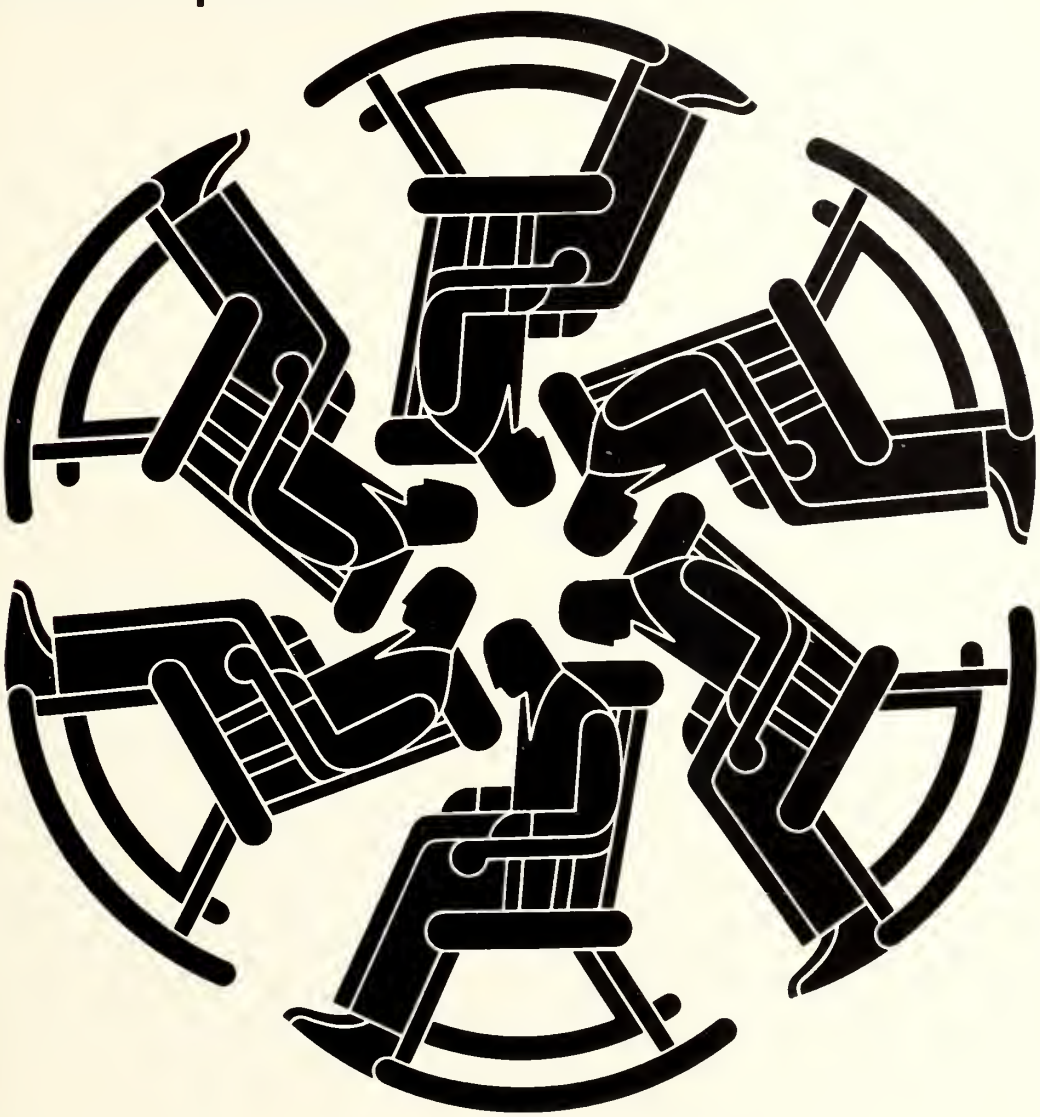
Professional competence or obsolescence—which? This is the question of the day. The answer is of first moment to the future doctors now in the making and their teachers in medical schools, to physicians now in practice and to the public who must be assured of the finest and highest quality health care that our advanced scientific society is now capable of producing for them.

A Taxonomy of Scholarly Endeavor

There is a viewpoint prevalent among medical teachers and physicians to the effect that short postgraduate courses are the encompassing beginning and the end of continuing education, and that the number of courses presented by a medical school and the number attended each year by the practicing doctor is a full measure of achievement in keeping up to date. It is doubtful if salvation cometh from the postgraduate course equivalent of the dutiful,

(Continued on Page 718)

for the debilitated geriatric patient



Berocca®

TABLETS
high potency B-complex and C
for nutritional support

AVAILABLE ONLY ON Rx

contains water-soluble vitamins only

b.i.d. dosage

good patient acceptance

no odor, and virtually no aftertaste

Each Berocca Tablet contains:

Thiamine mononitrate	15 mg
Riboflavin	15 mg
Pyridoxine HCl	5 mg
Niacinamide	100 mg
Calcium pantothenate	20 mg
Cyanocobalamin	5 mcg
Folic acid	0.5 mg
Ascorbic acid	500 mg

Usual dosage is one tablet b.i.d.

Indications: Nutritional supplementation in conditions in which water-soluble vitamins are required prophylactically or therapeutically.

Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B_{12}.

Dosage: 1 or 2 tablets daily, as indicated by clinical need.

Available: In bottles of 100.

ROCHE

Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

(Continued from Page 716)

somnolent passivity of resting in a pew on Christmas and Easter Sunday each year.

Continuing postgraduate medical education is a scholarly way of life, the sole purpose of which is the ultimate provision of constantly improving, high-quality patient care thereby assuring abundant national health and vigour.

If continuing medical education is not a short course but a scholarly way of life, then the question may well be asked—What is its nature and scope? What guidelines can be delineated to assist the practicing physician to plan his own program of life-long learning? In order of decreasing rank, though all are of essential importance, five basic forms of continuing medical education are suggested. This guideline "Taxonomy of Scholarly Endeavour," modified from the Vollan Report,[5] provides a scale by which a doctor, teacher, medical school, hospital, medical community, or nation may measure achievement in continuing medical education.

Continuing postgraduate medical education is:

1. The scholarly habit of planned daily reading and study in a home library-sanctuary as an integral part of a doctor's workday; *and* it is
2. The periodic return every three to five years for three months or more of intensive study in the teaching hospital to reinforce scholarly motivation and attitudes and to acquire new skills and knowledge; *and* it is
3. The day-to-day informal and formal colleague-association in patient care in the community and teaching hospital, in group practice and by consultation; *and* it is
4. The attendance at scientific sessions of learned professional societies, always associating such participation with relevant *pre-session and post-session reading and study in the home library-sanctuary; and* it is
5. The attendance at short courses which incorporate in their design a *pre-course and post-course guided reading program to be undertaken in the home library-sanctuary.*

The five components of the foregoing taxonomic list constitute an indivisible unit of continuing education endeavour in which the amalgam that binds the components together is *self-learning*—the studious, planned hours spent by the physician in his home library-sanctuary.

Because the ultimate goal on continuing education is the provision of high-quality care, each doctor will relate his own personal program of continuing education to the specific needs and specific problems of his patients. Consequently, the application of the "taxonomy" will produce for each physician a highly individualized program. He alone can set his own curriculum. He alone can select or reject what is relevant or irrelevant to the best care of his patients. He alone can be moved with a sense of compassionate trust to seek out for the benefit and comfort of his trusting patients the advances in the basic medical, clinical, behavioural, biological and engineering sciences which will best promote their health, prevent their illness, cure their disease and alleviate their suffering.

The Home Library-Sanctuary

Like the constantly progressing depreciation of the purchasing value of money, professional obsolescence is an unremitting, relentless, erosive process which demands astute, planned, continuing, corrective action. For the doctor this means: adequate time, the quietude of a home library-sanctuary, and a collection of carefully selected, reliable book and periodical resources on the library shelves, so that he may studiously accomplish three distinct acts of personal continuing education:

1. *Identify* new information relevant to the care of his patients.

2. *Reinforce,* by periodic review, previously acquired essential knowledge before it slips silently from the grasp of his conscious recall.

3. *Discard* that which is no longer relevant to the good care of his patients.

Stelson,[6] of the Carnegie Institute of Technology, in reference to obsolete engineers concludes:

"New knowledge in the field is developing so rapidly that a practicing engineer must spend about ten per cent of his time extending his knowledge just to maintain his relative position in the profession. But this figure assumes that he retains all his previous training, an achievement rarely encountered. Therefore, a more realistic estimate is that he must spend 20 per cent of his time acquiring new knowledge if he wishes to maintain his value to his employer and to society. If he wants to forge ahead, he will probably have to devote about one-third of his time and energy to self-education and improvement."

If this is true for engineers, how much more so for doctors entrusted with the life of patients. It is suggested that *for a good doctor, not less than one hour a day or half-day a week is a bare minimum of time for the reading and study necessary to ward off professional obsolescence.*

Schisgall,[7] in "What You Can Do With An Hour A Day," telling of what some distinguished world figures have accomplished, states:

"If you devote but one hour a day to an engrossing project you will give it 365 hours a year, or the equivalent of more than 45 full working days of eight hours each. This is like adding one and a half months of productive living to every year of life! Yet, when I talk about an hour a day of privacy for self-development, the reply is apt to be: 'I'm too busy. I work all day. When I come home I'm exhausted. I want some time with the children.' Admittedly, it is not easy. It requires resolution. The trick is to create the hour, then use it wisely."

The Teaching-Hospital Sabbatical Pilgrimage

The value of a periodic return to the teaching-hospital environment cannot be over-emphasized. This learning experience should be a *sabbatical must* every three to five years. Freed from the pressures of practice for three months or more, it "recharges the batteries" of scholarly motivation; it reinforces good practice attitudes and habits; it provides an opportunity to acquire new skills—diagnostic, therapeutic, operative; it re-exposes to the stimulus of academic-level ward rounds, conferences and seminars; it opens the doors to rich library resources; and it involves the physician in formal and informal personal confrontation with the enquiring minds of teachers, research scientists, fellows, residents and interns.

This essential form of postgraduate education must of necessity be highly individualized. For each doctor, the three-month or longer experience will be specially designed to meet the special needs of his patients and to suit his own personal interests in practice. Nepotism, provincialism or even nationalism should not be determining factors in the decision of where a doctor will seek this continuing education. He should select what, for him and for his patients, is the very best teaching hospital or series of hospitals, wherever situated on the face of the earth.

Peer Association in Learning

There is a tendency to overlook the very substantial amount of continuing education that goes on unobtrusively from day to day, year in, year out, through the informal and formal association of doctors in the course of caring for their patients. It takes place by the bedside, in the hospital corridor, over cups of coffee, in the group-practice office suite, by local and long-distance phone, and it not infrequently spills over at the "19th hole" or intrudes at an after-five party. "Wherever two or more are gathered. . ." to

paraphrase Holy Writ, doctors will probably be talking, among other things, about patient care problems.

More formally, in the community hospital, destined, I most sincerely hope, to assume a major and increasingly important role in postgraduate medical education, activities such as ward rounds, medical staff meetings, clinicopathological and radiological conferences, tissue committee studies, medical audits of patient care, serial patient-management, reviews, journal clubs, etc., are invaluable learning experiences which constantly up-grade the quality of care not only in the hospital but also in the office practices of the medical staff and thereby in the entire community served by the hospital.

This is a crucial and overwhelming argument for making absolutely certain that family physicians are a part of and play a significant role in every hospital.

The consultation, whether by personal confrontation, by letter or by telephone, continuously and imperceptibly diffuses innovation and leavens the quality of patient care. Reliable information on the latest and proved new drug, its use, its dosage and its dangers, is but seconds away from every doctor. It is as close as the phone that associates the enquiring doctor with his answering professional peer resource, be he 100 yards or 100 miles distant. The telephone, bringing two physicians together in therapeutic enquiry, is one of the most valuable single devices in the field of new drug continuing education. "When in doubt phone a professional peer resource for reliable information on new drugs!"—this should be a guiding therapeutic principle for every doctor if he wishes his trusting patients to have the unbiased best and safest drug at the lowest cost.

The growth of group practice facilitates the diffusion of new knowledge and the acquisition of new skills among group-practice colleagues through personal association in the office suite and by sharing patient-care responsibilities in the community hospital. A further continuing education benefit of group practice is the opportunity it provides periodically for each member of the group to attend the scientific sessions of learned professional societies and short courses. Further, group practice makes it easy for the sabbatical return of its members, periodically, to the teaching hospital.

The Learned Medical Society in Scientific Session

Few professions can equal the degree of vigour and amount of scholarly endeavour which takes place annually in the scientific sessions of its numerous learned medical societies—local, regional, national and international—which convene to deliberate on advances in the basic medical, clinical and related sciences. Its favourable impact on the quality of patient care must be immeasurably great and beneficient. The "taxonomy" presented underlines that the value of each session would be substantially enhanced by pre-session distribution (six weeks ahead at least) of all papers, or an outline of each, with related key references. This would permit each physician using his home library-sanctuary to review the subjects and would prepare him to participate with searching intelligence during the discussion periods of the scientific meeting. Implicit in this concept is the view that scientific sessions generally might be more productive and stimulate more pre-session and post-session reading and study if the sessions were designed to allow more small-group exchange of views.

Short-Course Galvanic Stimulation

"Many who are first shall be last and . . ." Thus it is with the short or refresher course in the taxonomic hierarchy of continuing education endeavor. This is not to deny the great value of the increasingly popular short course. More and more first-class courses are being made available to the practicing physician. This is most praiseworthy. Often, however, a short course appears to be an exercise devoid of cerebration in which, hour after hour, row upon row of satiated, somno-

lent physicians are soothed and sedated by the susurrous sound of lengthy pontification intoned from a podium.

As with the scientific sessions of the learned medical societies, the value of short courses lies in associating each subject presented with a short but highly relevant list of *practical* references for pre-course and post-course reading. Short course subjects should always be meaningful in terms of the common needs of the patients of the doctors for whom the learning experience is being designed. In planning a course, two basic questions should be posed: What common disorders of the family group in the community concerned are being badly or poorly managed? What practical innovations, the product of scientific advance, should be introduced to improve the health care of the family group in the community? Half the course, and preferably much more, should be participative, thus enabling the practising doctors in small groups to set the agenda by the questions they direct to the teachers.

Above all, each teacher should be aware that participation in a short course is a very special teaching task. The teacher is not dealing with a captive undergraduate audience regimented in rows on schedule. He faces a group of physicians meaningfully and deeply involved every day in the drama of patient life and death—physicians who freely occupy the rows and pay a fee to do so! This requires of the teacher many hours of study in his own home library-sanctuary, poring over Miller's "Teaching and Learning in the Medical School"[8] and Verner's "Adult Education."[9] These basic references on the teaching-learning process are very relevant to his important contribution to a short course.

The short course should be recognized for what it is—simply and only, a brief, episodic, galvanic learning stimulation which is an utter waste of time for the doctor and teacher alike unless it motivates the doctor to continuous, inquiring, prying pursuit of new knowledge and new skills for the sole purpose of bringing the benefits of scientific innovation to his trusting patients.

A Scholarly Way of Life

Through the centuries the scholarliness of countless physicians, generation upon generation, has conferred upon the medical profession as a whole the recognition of a privileged position among the three time-honoured learned professions. Today this quality of scholarliness has become of public moment and expediency. What a physician does or does not do is increasingly in the white light of peer and public scrutiny. His patterns of practice and the quality of his patient care are now being observed, measured and assessed by the cybernetic monsters in the medicare offices of government. This process of evaluation is likely to increase. As it reveals and defines instances of failure to bring the benefits of modern advances to patients, it will undoubtedly prod, encourage and perhaps stimulate certain physicians who have failed their trusting patients to begin a planned program of keeping up to date.

The mounting public interest in physician competence is such that world leaders, including Ashby in the United Kingdom,[10] quoted editorially on "Selection and Obsolescence," and Gundersen,[11] in 1959 as the then President of the American Medical Association speaking on "Medical Responsibilities in a Changing World," have raised the issue of conditional licensure to practise with renewal based on evidence of continuing scholarly pursuit. The threatening goad of conditional licensure may frighten and coerce some obsolescent physicians into studious ways, but let it be said and underlined that compassion and a sense of trust for patients have been, are, and always will be the only enduring and effective forces that move a good physician to be a life-long learner on behalf of his trusting patients. Of "the goodness of the physician," Hippocrates wrote long ago that: "Where there is love of man, there is also love

of the art." This is the beginning and end of all postgraduate medical education.

A Good Doctor Is Not A Soloist!

Today a good doctor is just one member of a health care team—a team that is steadily growing in numbers, in specialization of functions and in sophistication of skills. Today a doctor can no longer practise unto himself and provide his patients with high quality care. He cannot fulfill the trust of his high calling unless he assures his patients of the special skills and dedicated devotion of the large group of health care colleagues who constitute the essential membership of the modern health care team.

Within living memory the doctor's sole associate in the delivery of health care was his horse. Then came the doctor's first team colleague—the nurse. As the product of science and technology began to pour forth in full flood the ratio of one doctor to one nurse steadily changed until in many communities the ratio is now one doctor to at least 15 other health care professionals.

During the past ten years the concept of the health sciences team as the new primary functional unit in the provision of health care has captured the attention of medical schools, teaching hospitals, health departments, the health science professions and the public generally. Witness the great new health sciences centres arising across the face of the earth dedicated to the view that high quality health care can only be provided by the cooperative, coordinated endeavour of many well-trained, highly qualified, experienced men and women using the proven new advances of all the sciences.

In 1968 a Division of Continuing Education in the Health Sciences was established at The University of British Columbia. Representatives of 11 health sciences on campus began to organize and function together in common accommodation, with common programming activities, as a continuing education leader group. This group included a representative from dentistry, hospital administration, library science, medicine, nursing, nutrition-dietetics, occupational therapy, pharmacy, physiotherapy, psychology, social work and a member responsible for developing the concept of interprofessional undergraduate education in the UBC Health Sciences Centre.

This group, being unable to identify a published definition of a "health sciences team," set as its first team-task the construction of one which would embody Dean J. F. McCreary's basic concept for The University of British Columbia's Health Sciences Centre.[12,13] This proved to be an invaluable melding mechanism for the health sciences continuing education leader group. After six months of philosophical consideration and dynamic exchange of views, a growing consensus produced a draft definition which portrays to some degree the general dimensions of the group's concept of a health sciences team:

> A *Health Sciences Team*[1] is a group of health professionals[2] with their respective associated technologists, technicians and other essential personnel,[3] whose overall goals[4] are the promotion of health,[5] the prevention of disease, the diagnosis and treatment of illness and the alleviation of suffering, who, by cooperation[6], coordination[7] and integration[8] of effort provides health care embracing the sumtotal of relevant knowledge, skill and technology produced by all the sciences[9] and is applicable by the other learned professions[10], and who recognize every healthy or apparently-well person[11] each patient, the family and the community as integral participants in the process of providing this care.

To indicate to some extent the scope of the group's philosophical considerations in developing the foregoing draft definition an explanatory glossary with brief notes is presented:

1. *team*—set [group] of persons working together, combined effort, organized cooperation. (Oxford Concise Dictionary)

2. *professional*—(variously defined but for these purposes) a university graduate in an academic field with relevance to the provision of health care in the community, including dentistry, hospital administration, library science, medicine, nursing, nutrition-dietetics, occupational therapy, pharmacy, physiotherapy, psychology, social work and others.

3. *essential personnel*—a wide range of most important individuals including executive personnel, administrative assistants, secretarial, clerical, maintenance staff, and others.

4. *overall goals*—listed in a suggested rank order with "promotion of health" being first and paramount.

5. *health*—"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (World Health Organization)

6. *cooperation*—to work together to the same end [goal]. (OCD)

7. *coordination*—to bring [parts] into proper relation. (OCD)

8. *integration*—to combine [parts] into a whole. (OCD)

9. *all the sciences*—physical, chemical, biological, basic medical, clinical, social, computational, engineering and others.

10. *other learned professions*—architecture, education, law, religion and others.

11. *apparently-well person*—appearing healthy but presymptomatic disease revealed by skilful examination including multiphasic testing.

The foregoing will make apparent the comprehensiveness of the concept of the health sciences team, its membership, goals, supporting resources and functional principles, as envisaged by The University of British Columbia's Division of Continuing Education in the Health Sciences.

There was a day, quite a long time ago, when the doctor was a soloist occupying the centre stage all alone in the drama of life and death. That day is gone, never to return. Today, the good doctor is a lifelong learner and the active coordinator of a comprehensive health care team dedicated to the promotion of health, the prevention of disease, the diagnosis and treatment of illness and the alleviation of suffering.

This presentation began with an exerpt from a prayer by the great physician whom Sir William Osler called "the prince of Hebrew physicians." It seems appropriate that the lecture conclude with some pertinent words about continuing education from Osler himself,[14]

> "There are many problems and difficulties in the education of a medical student, but they are not more difficult than the question of the continuous education of the practising doctor. Over the medical student we have some control, over the other, practising doctor, none. The university and the licensing authorities make it certain that the medical student has a minimum, at least, of professional knowledge, but who can be certain of the state of the knowledge of the doctor in practice in five or ten years from the date of his graduation?—the conditions of his existence demand that he shall be abreast of the times. The family doctor should be carefully nurtured by the medical schools and carefully guarded by the public. Humanly speaking, with him are the issues of life and death, upon him falls the grievous responsibility in those terrible emergencies which bring darkness and despair to so many households. No class of men needs to call to mind more often the wise comment of Plato that education is a life-long business."

References

1. Whitteridge, D.: Learning and Relearning, Lancet, 2:192, 1959.

2. Welch, W. H.: Bull. Harvard Med. School A., 55, Jun., 1892.

3. Editorial: Medical Services J. Canad. 289, Mar., 1964.

4. Item: Newsweek 86, Dec. 4, 1967.

5. Vollan, D. D.: A Report: Postgraduate Medical Education in the United States. Council on Medical Education and Hospitals, American Medical Association.

6. Stelson, T.: Saturday Review, 44:61, May 20, 1961.

7. Schisgall, O.: Reader's Digest, 86:206, April, 1965.

8. Miller, G. E. et al: Teaching and Learning in the Medical School, Harvard University Press, Cambridge, 1961.

9. Verner, C.: Adult Education, The Center for Applied Research in Education, Inc., Washington, 1964.

10. Editorial: Brit. Med. J., 2:577, 1963.

11. Gundersen, G.: J. A. M. A., 170-280, 1959

12. McCreary, J. F.: Canad. Med. A. J., 86:634, 1962.

13. McCreary, J. F.: World Hospitals, 4:23, 1968.

14. Osler, W.: Address: New Haven Medical Association, Jan. 6, 1903.

INDEX TO ADVERTISERS

Arch Laboratories 626

Blue Cross-Blue Shield 715
The Bradley Center 697
Breon Laboratories 639, 640, 641, 642
Burroughs Wellcome 679

Campbell Soup 667
Classified 636

Geigy 680, 681, 682
Glenbrook Aspirin 685
Guest House Motel 691

Highland Hospital 630
Hynson, Westcott & Dunning 615

Lederle Laboratories 617, 627, 705
Eli Lilly & Company ..... 1st Cover, 648

Majorcan Carnival 631
Wm. S. Merrell Company 707

National Drug Company ..... 2nd Cover, 621, 622

Parke Davis & Company 701, 702
Wm. P. Poythress & Co., Inc. 700

A. H. Robins ..... 670, 3rd Cover
Roche Laboratories ..... 645, 717, 4th Cover

Sandoz Pharmaceuticals 699
G. D. Searle & Company 668, 669
The Stuart Company 625

Wyeth Laboratories 710, 711

The AMBAR® SCRAPBOOK of Obesity Oddities
FACT & LEGEND



NTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS

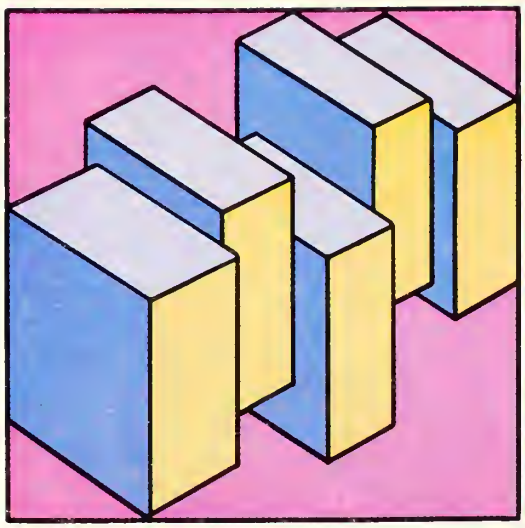
methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

Ambar Extentab before breakfast can control most patients' appetite for up 2 hours. Methamphetamine, the appesuppressant, gently elevates mood and s overcome dieting frustrations. Phenoital, the sedative in Ambar, controls irritability and ety... helps maintain a state of mental calm and equaty. Both work together to ease the tensions that erode willpower during periods of dieting.

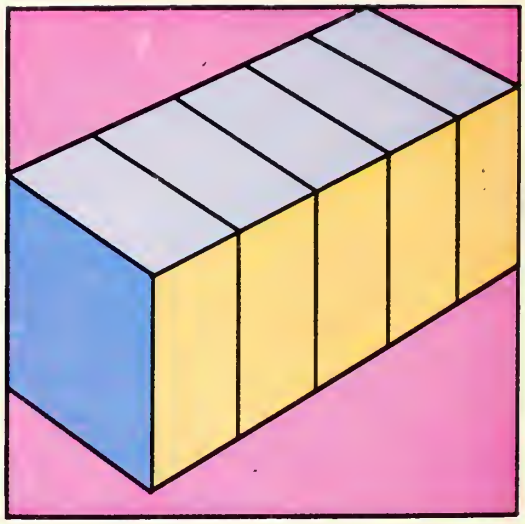
available: Ambar #1 Extentabs®—methamphetamine ochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warnmay be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS



from the discord of anxiety...



to emotional harmony

Before prescribing, please consult complete product information, a summary of which follows:

INDICATIONS: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.
CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.
WARNINGS: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
PRECAUTIONS: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
ADVERSE REACTIONS: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido--all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

with the aid of antianxiety

Librium®
(chlordiazepoxide HCl)

5-mg, 10-mg and 25-mg capsules

In an age of swift change and challenge, susceptible individuals may experience varying degrees of excessive anxiety. The resulting emotional stress may precipitate significant functional disorders or complicate existing organic disease. In properly individualized maintenance dosage, Librium (chlordiazepoxide HCl) quickly helps relieve anxiety and apprehension, provides useful adjunctive therapy in psychophysiologic disorders. In long clinical experience, Librium has demonstrated a wide margin of safety.

Also available:
Libritabs®
(chlordiazepoxide)

ROCHE
Roche LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

JOURNAL of the Medical Association of the State of ALABAMA

ASSOCIATION OF THE STATE OF ALABAMA
DISPLAY
FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON
12 MAR 1970

IN THIS ISSUE

Early Recognition and Prompt Evaluation of Spinal Deformity 749

Pulmonary Function Testing for the General Hospital and Physician (Part III) 756

Hobbies to Fill a Doctor's Leisure The Most Intriguing of These is Politics . . 771



Francis A. Countway Library of Medicine
10 Shattuck St.
Boston, Massachusetts 02

FEBRUARY 1970

The girth control pill



Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride)

works on the appetite not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epile on increase in convulsive episodes has been reported. Sympathomimetic ca *vascular effects* reported include ones such as tachycardia, precordial p arrhythmia, palpitation, and increased blood pressure. One published re described T-wave changes in the ECG of a healthy young male after ingesti diethylpropion hydrochloride; this was an isolated experience, which has not reported by others. *Allergic phenomena* reported include such conditions as urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diar constipation, nausea, vomiting, and abdominal discomfort have been repo Specific reports on the hematopoietic system include two each of bone ma depression, agranulocytosis, and leukopenia. A variety of miscellaneous act reactions have been reported by physicians. These include complaints such a mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decre libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. t daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet times daily, one hour before meals. If desired, an additional tablet may be gi midevening to overcome night hunger. Use in children under 12 years of age recommended.

T-006A / 1/70 / U.S. PATENT NO. 3,0

THE NATIONAL DRUG COMPA
DIVISION OF RICHARDSON-MERRELL
PHILADELPHIA, PENNSYLVANIA 19

Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

N THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF REMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

LUTREXIN, the non-steroid "uterine elaxing factor" has been found to be useful y many clinicians in controlling abnormal terine activity.

Literature on indications and dosage available on request.

- No side effects have been reported, even when massive doses (25 tablets per day) were administered.
- Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. BALTIMORE, MARYLAND 21201

(LTR23)

THE JOURNAL

of the

Medical Association of the State of Alabama

Volume 39 • February, 1970 • No. 8

Office of Publication
19 So. Jackson St. .... Montgomery, Ala. 36104
Subscription Price ..... $5.00 Per Year
$1.00 Per Copy

Second Class Postage Paid at Montgomery, Alabama. Published monthly in Montgomery at 19 South Jackson Street.

Editor-in-Chief
William L. Smith, M. D. ..... Montgomery

Managing Editor
L. P. Patterson ..... Montgomery

Assistant Managing Editor
Mary Nell Williford ..... Montgomery

Associate Editors
J. P. Collier, M. D. ..... Tuscaloosa
John M. Chenault, M. D. ..... Decatur
M. Vaun Adams, M. D. ..... Mobile

Officers of the Association

President
C. Kermit Pitt, M. D. ..... Decatur

President-Elect
S. Buford Word, M. D. ..... Birmingham

Vice-Presidents
F. M. Phillippi, Jr., M. D. ..... Brewton
J. E. Cameron, M. D. ..... Alexander City
O. Emfinger, M. D. ..... Union Springs
Wood S. Herren, M. D. ..... Birmingham

Secretary-Treasurer
William L. Smith, M. D. ..... Montgomery

Executive Director
L. P. Patterson ..... Montgomery

The State Board of Censors
John M. Chenault, M. D., Chmn. ..... Decatur
J. P. Collier, M. D. ..... Tuscaloosa
Hugh E. Gray, M. D. ..... Anniston
Paul W. Burleson, M. D. ..... Birmingham
L. L. Hill, M. D. ..... Montgomery
M. Vaun Adams, M. D. ..... Mobile
J. D. Bush, M. D. ..... Gadsden
E. L. Strandell, M. D. ..... Brewton
John W. Davis, Jr., M. D. ..... Montgomery
J. Garber Galbraith, M. D. ..... Birmingham

State Health Officer
Ira L. Myers, M. D. ..... Montgomery

Delegates and Alternates to the American Medical Association

(Terms expiring December 31 of year shown.)

1970
Delegate—E. Bryce Robinson, Jr., M. D., .. Fairfield
Alternate—W. E. White ..... Anniston

1971
Delegate—M. Vaun Adams, M. D. ..... Mobile
Alternate—E. L. McCafferty, Jr., M. D. ..... Mobile
Delegate—P. W. Burleson, M. D. ..... Birmingham
Alternate—Robert Parker, M. D. ..... Montgomery

CONTENTS

President's Page 728

The Woman's Auxiliary 730

Editorial Comment 734

News Media Creating Substitutes For Medicine's Heroes 734

. . . Til Leap Year Gives It Twenty-Nine 736

Will Doctors or Others Blueprint Tomorrow's Medical Care? 736

Legal Page 739

Taxation And The Professional Corporation 739

The Month In Washington 740

Scientific Section 749

Early Recognition And Prompt Evaluation Of Spinal Deformity, Walter P. Blount, M. D., Milwaukee, Wisconsin 749

Pulmonary Function Testing For The General Hospital And Physician (Part III), D. S. Tysinger, M. D., Dothan 756

Around The State 765

Vital Statistics 765

Hobbies To Fill A Doctor's Leisure 771

The Most Intriguing Of These Is Politics 771

Mobile Doctor Among Ten 50-Year Club Additions For 1970 779

A Mobile Flying Doctor 779

Fathers And Sons In Medicine 780

Germany At War Altered Starting Careers Of Both McVays 780

The Doctors Daniel—An Alabama Trio 781

Federal Bureau Of Narcotics Lists 15 Don'ts For Doctors 782

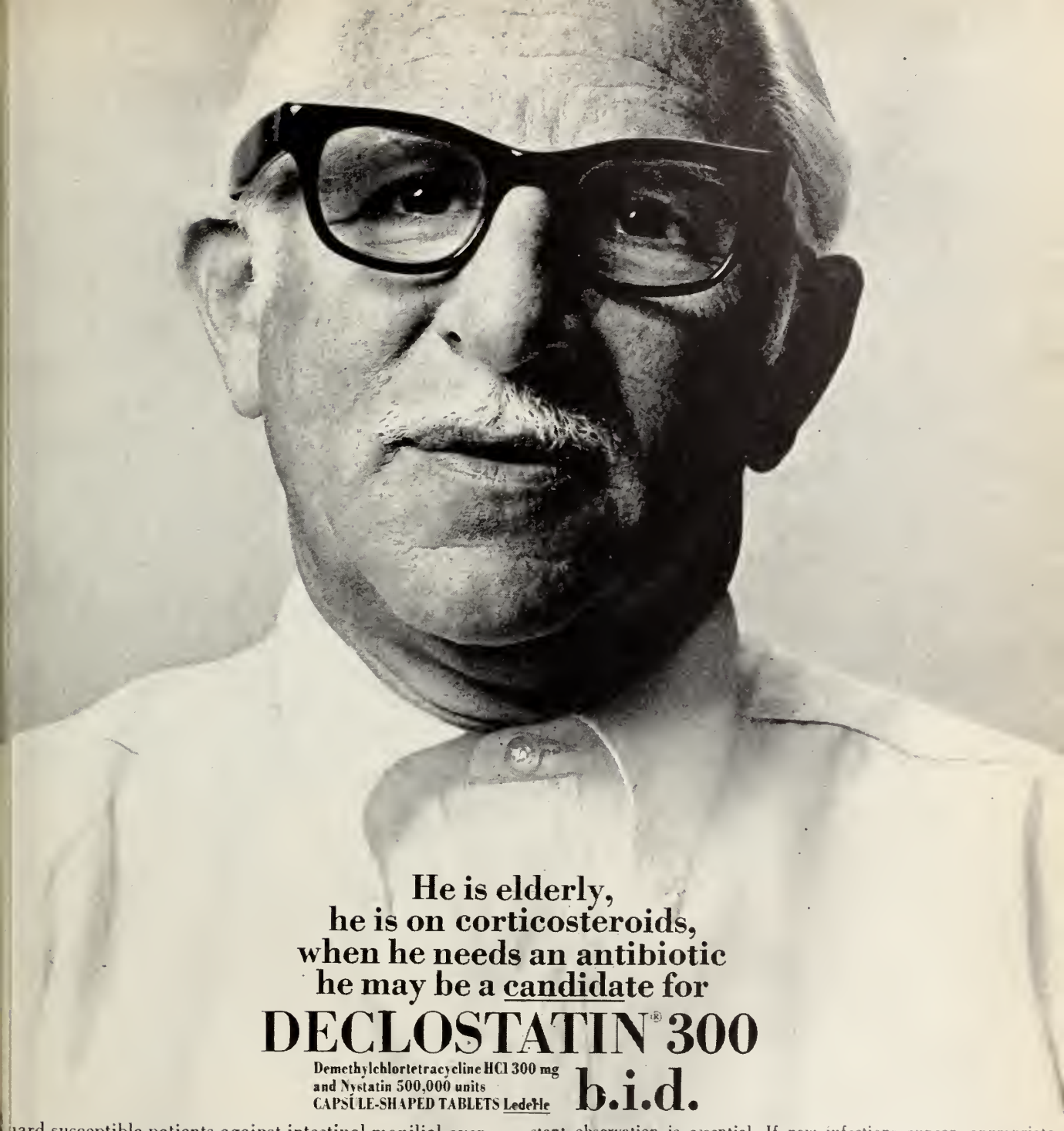
Physician Placement Service In Alabama 788

Association Forum 791

Rising Medical Care Costs—What To Do? 791

New Type Anesthesia May Prove Major Discovery 793

Alabama Department Of Public Health 795



He is elderly,
he is on corticosteroids,
when he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

uard susceptible patients against intestinal monilial over- th during broad-spectrum therapy—the protection of satin is combined with demethylchlortetracycline in LOSTATIN.

r your susceptible candidates, prescribe DECLOSTATIN broad-spectrum therapy that prevents monilial growth.

aindication: History of hypersensitivity to demethylchlortetracy- or nystatin.

ng: In renal impairment, usual doses may lead to excessive accumu- and liver toxicity. Under such conditions, lower than usual doses dicated, and, if therapy is prolonged, serum level determinations e advisable. A photodynamic reaction to natural or artificial sun- has been observed. Small amounts of drug and short exposure may ce an exaggerated sunburn reaction which may range from ery- to severe skin manifestations. In a smaller proportion, photo- ic reactions have been reported. Patients should avoid direct ure to sunlight and discontinue drug at the first evidence of skin nfort. Necessary subsequent courses of treatment with tetracy- should be carefully observed.

utions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

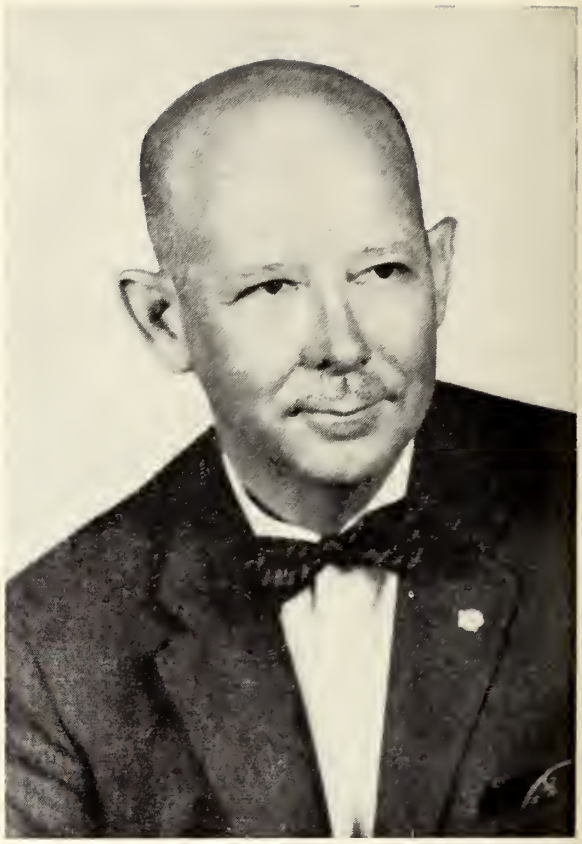
Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

President's Page



C. Kermit Pitt

One of the more rewarding experiences of the office of President is the opportunity to work with physicians throughout Alabama who hold responsible jobs as officers and members of committees of this Association.

The high dedication which these men bring to their assigned task is indication in itself that the future of the medical profession is in no immediate danger. Indeed, if the young men and women who are now entering our ranks will put their shoulders to the wheel with the same enthusiasm and diligence of those who now serve, there is a distinct possibility that the accomplishments of organized medicine will be multiplied manifold in the years ahead.

As this Association comes to the climax of its fiscal year with the Annual Session at Mobile, Alabama, April 30-May 2, I am able to look back upon my brief tenure as President with pride in our accomplishments and confidence that this will prove an epic year in the history of the Association. Without the assistance of the officers and committees at both the state and county levels this would not have been possible.

C. Kermit Pitt, M. D.

Why Always Half A Dose

"Take two mornings and call me in the aspirin," the sleepy doctor advised his telephone patient, according to Dr. Frank Cole, editor, *The Nebraska State Medical Journal,* and then wonders editorially:

"If we want the patient to take something, why take two? Whatever happened to one? We can honestly claim to have done no research here, which puts us in an unenviable position. For we think that if you can get half the dose into a pill or tablet, you should be able to get it all. Without investigating all the drugs in our medicine cabinet, there is too much of a coincidence in assuming that it takes two pills or two tablets of every drug to contain a single dose . . . Everybody takes two and, besides, you can always break a tablet."

for the debilitated geriatric patient



Berocca®

TABLETS
high potency B-complex and C
for nutritional support

AVAILABLE ONLY ON Rx

contains water-soluble vitamins only

b.i.d. dosage

good patient acceptance

no odor, and virtually no aftertaste

Each Berocca Tablet contains:

Thiamine mononitrate	15 mg
Riboflavin	15 mg
Pyridoxine HCl	5 mg
Niacinamide	100 mg
Calcium pantothenate	20 mg
Cyanocobalamin	5 mcg
Folic acid	0.5 mg
Ascorbic acid	500 mg

Usual dosage is one tablet b.i.d.

Indications: Nutritional supplementation in conditions in which water-soluble vitamins are required prophylactically or therapeutically.

Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B_{12}.

Dosage: 1 or 2 tablets daily, as indicated by clinical need.

Available: In bottles of 100.

ROCHE

Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

The Woman's Auxiliary

President, Mrs. Ben H. Johnson, Jr.
President-Elect, Mrs. Howard C. Johnson
Northeast District Vice President, Mrs. James D. Holliman, Jr.
Northwest District Vice President, Mrs. Gene Qualls
Southeast District Vice President, Mrs. George Andrews
Southwest District Vice President, Mrs. Andrew D. Henderson
WAMASA Editor, Mrs. William L. Smith

AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the Medical Association of the State of Alabama. I will support its activities, protect its reputation and ever sustain its high ideals."

Auxiliary members are busy with projects that will help not only our own communities but also groups outside our country that depend on us. Project Hope is actively supported and our International Health chairman, Ruth Camp of Huntsville, is working hard with the county chairmen on a project. The new committee on Children and Youth has an energetic lady, Frances Wideman of Birmingham, heading this committee. She has sent out letters and arranged a meeting of interest to her chairmen. Health Careers is an important committee and Annie Bradley of Centre is spreading the word about the Health Careers Day that will host High School students from all over Alabama. Our Safety chairman, Ann Noble of Fort Payne, has a big, big idea up her sleeve that will be of interest to doctors and their families all over Alabama. The Legislative chairman, Rae Hansberry, of Decatur, is not idle and the counties are working, you will be hearing from us!

A delightful visit to the Madison County Auxiliary in December convinced me that Auxiliary members are actively interested in their community. These busy girls were discussing three or four projects of importance and one that was a request from the doctors in the medical society. This is just what we aim for and we are ready and willing to lend a hand wherever the need. The theme for this administration "We Help" is showing up in these many areas, and I address this plea to the medical societies. Where we are needed let us know. Time is too valuable to "just belong," Auxiliary members do not drift along, they pitch in and HELP.

On a recent visit to Mobile I was impressed with the Hospital Auxiliary work

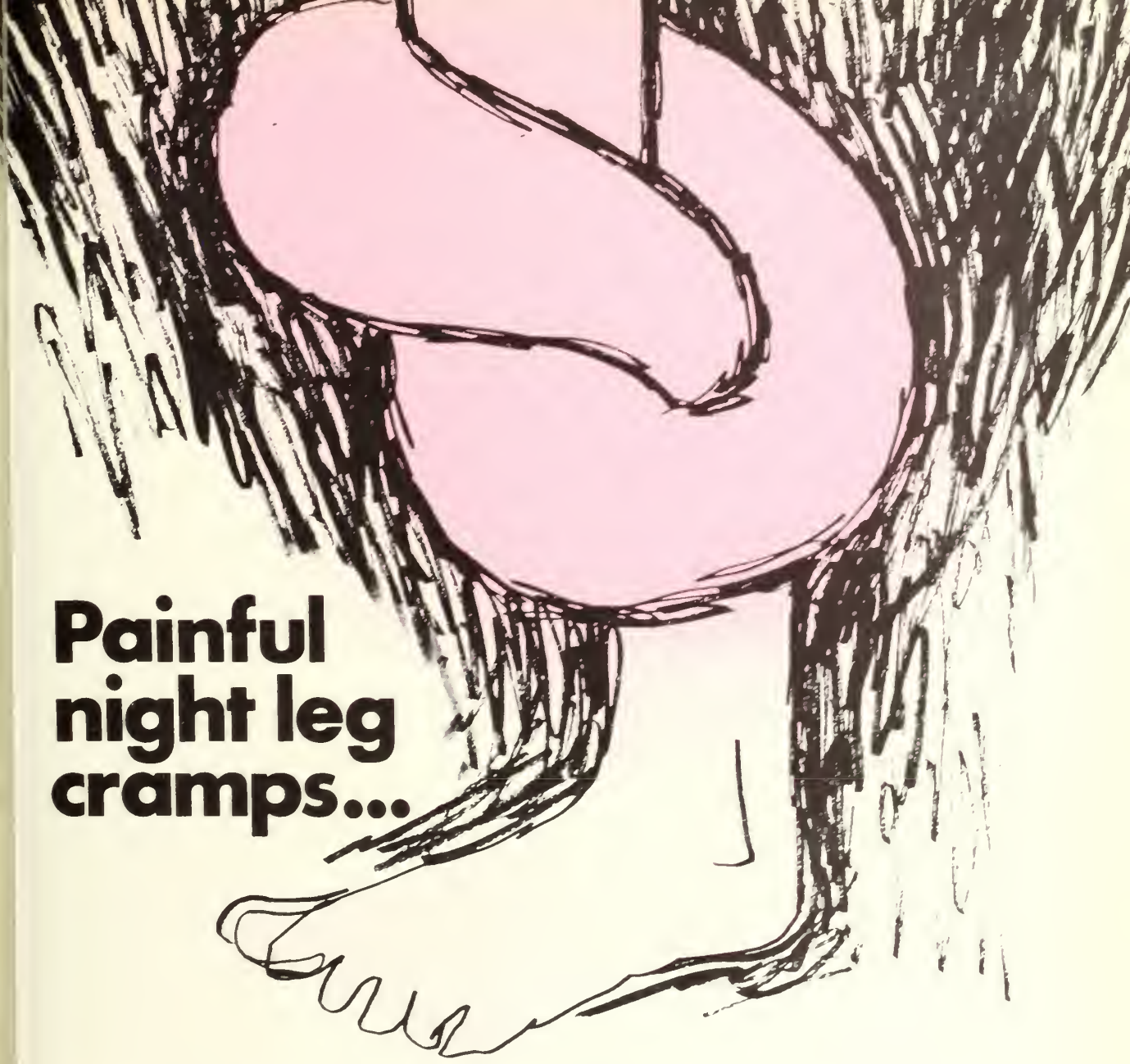


Mrs. Ben H. Johnson

these busy girls undertake. They are a creative group and I came home loaded down with darling "Swedish good luck Christmas Tree ornaments" sold to aid hospital auxiliary funds, and other wonderful items these girls had made.

And, now, we come down to the big question. Just why do doctors and their wives attend the state conventions of the Medical Association and of the Auxiliary? Is it to have a good time, for a shopping trip, a rest away from the children and the many home

(Continued on Page 733)



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg.; Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™ Specific therapy for night leg cramps

(quinine sulfate 260 mg., aminophylline 195 mg.)

G915A



Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC — the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem —
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive — Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfanamides.
Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.
Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream — Four-ounce tube with or without applicator. Suppositories — Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriera, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerna, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

AVC CREAM (aminacrine hydrochloride 0.2%, sulfanilamide 15.0%, allantoin 2.0%)

SUPPOSITORIES (aminacrine hydrochloride 0.014 Gm., sulfanilamide 1.05 Gm., allantoin 0.014 Gm.)

TRADEMARK A V C

AV-919A 7/69

(Continued from Page 730)

responsibilities? These reasons are good enough, any one of them will do, and at the same time we can attend to Auxiliary business and to the business of the Medical Association.

It is the task of the state presidents of both groups to plan a convention that will teach, inspire, and entertain, while including the necessary business of the convention. The delegates to the convention comprise the governing body of both the Medical Association and the Auxiliary, and this is the time that many important decisions are made. All members are welcome and urged to attend, and we would hope that many will come because they are interested and care what decisions are made that may affect the future of both groups.

There are many details attending the planning, and the local convention chairmen take care of a multitude of tasks. Mobile is an ideal convention city. The accommodations of the Municipal Auditorium with nearby motels, the promise of spring in the air in late April, and the warm hospitality of the host society and Auxiliary will lure many of us. If you have suggestions that will make the convention more attractive to you and to your wife, now is the time to say. Let us know just how anxious you are to attend this exciting convention and just what would make this event more outstanding, of enough importance for you to take time to join us in Mobile on April 30, 31, and May 1.

We know you are coming, and we are already "baking cakes"!

Ruth R. Johnson

(Mrs. Ben H. Johnson, Jr.)

President, WAMASA

Million-To-One Shot!

The man who was awarded the first Gold Medal of the American College of Radiology has accomplished another "first"— he gets to spend his own life insurance.

William D. Coolidge of Schenectady, New York, won the medal in 1927, and now, at the age of 96, he has received two checks covering his Northwestern Mutual Life Insurance Co. policies taken out 61 years ago.

A teacher, scientist and inventor, Dr. Coolidge is a former director of the General Electric Research Laboratory. His studies and inventions have yielded important contributions to science and vast benefits to mankind.

Back in the days when Dr. Coolidge purchased his life insurance, all rates were calculated on the assumption that of a million persons born at that time only one would survive to age 96.

Thus the noted scientist has beaten one million to one odds.

—ACR Bulletin

Ulcer Re-lief!

Dicarbosil®
ANTACID

Your ulcer patients and others will respond favorably to it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102



News Media Creating Substitutes For Medicine's Heroes

Is logorrhea (excessive talkativeness) primarily responsible for damaging the medical image?

Irvine H. Page, M. D., a Cleveland cardiologist, former president of the American Heart Association, editor-in-chief of *Modern Medicine,* and 1968 recipient of AMA's Sheen Award, believes that it is. In a recent issue of *American Medical News* he details his thinking in an article captioned: "Medicine's Information Explosion."

Hiding behind a sham of humility, some researchers are rushing prematurely into print, realizing that their career, their very livelihood depends on their receiving recognition for their work, Dr. Page said, citing an early example when:

". . . the medical profession was thunderstruck by an announcement directly to the press" which "probably first occurred in a truly shocking form when the greatly respected Andrew Ivy, M. D., called reporters to the Drake Hotel in Chicago and announced the discovery of a cancer cure, krebiozen. Few of us could believe it! . . .

"Probably the next dramatic episode to highlight communication came when the so-called 'artificial heart' was announced. The peer group was largely by-passed and a circus atmosphere created by an avid press who saw the opportunity to make a great story with the help of cooperative physicians. This episode had hardly quieted down before the 'miracle of Cape Town' was upon us. . ."

Dr. Page points out that by going directly to the public and by-passing peer review, the advances in knowledge of medicine "must be evaluated by a scientifically uneducated and often naive public. The standards of achievement are being set by the public and the news media. Physicians are being told that heart transplantation is the greatest surgical feat of our century, comparable to the discovery of atomic energy! . . .

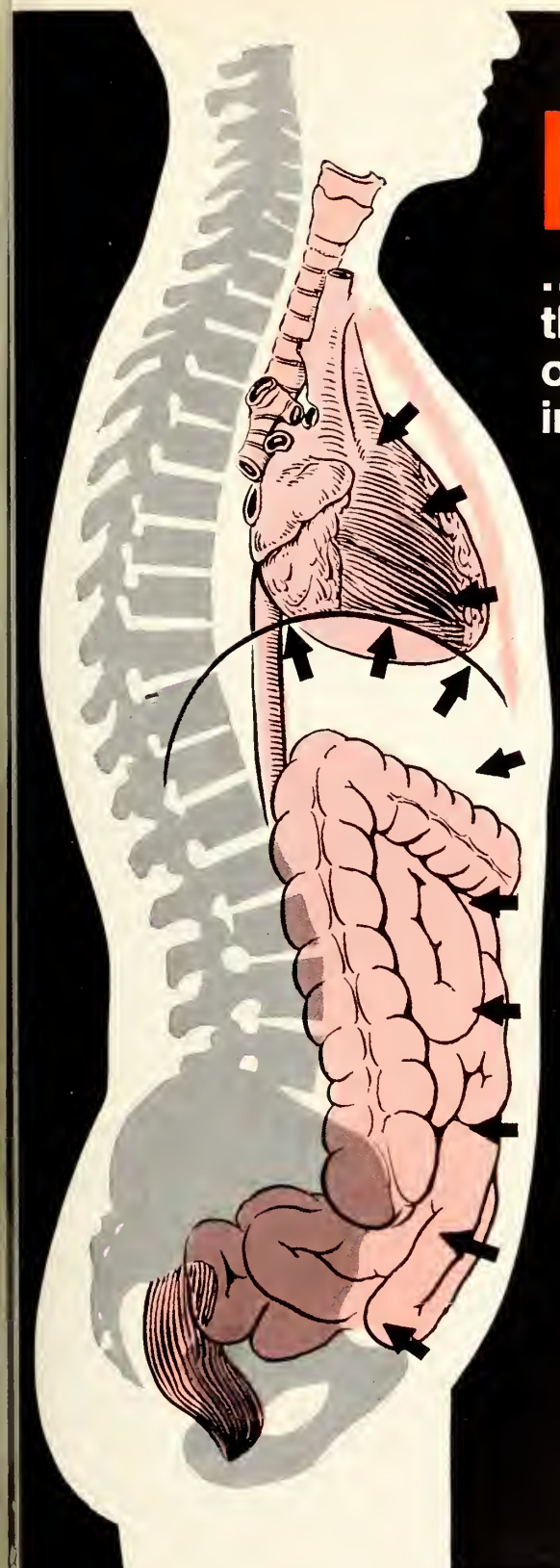
"The heroes of medicine are brushed aside to make room for the 'celebrities' created by the news media. . . We have capitulated to the contemporary standards of public morality and we will surely pay the price for it.

"Remember there was a time when personal reticence in physicians was thought commendable and advertising considered unethical. . . The power of fame and money is effacing the good taste which physicians had thought important but which is now often contemptuously dismissed by some of the public as hypocrisy."

If we continue, Dr. Page warns, "to countenance the abuse of reasonable and time-tested procedures for medical and scientific communications, whether from discoverers to peer groups or from discoverers to the public, we can expect ever growing disrespect and distortion of the social policies within which we must live and work."

Or, as a blaring newspaper headline reporting on last summer's AMA convention upset exclaimed: "Hip, Hip, Hippocrates!"

(Continued on Page 736)



DOXIDAN®

...to reduce the hemodynamic "bind" of constipation in congestive heart failure

Constipation in the chronic heart failure patient carries with it the ever-present threat of acute cardiac decompensation while straining at stool. In the already weakened, distended heart, a sudden influx of blood on termination of the Valsalva maneuver is considered to be the mechanism of some of the deaths occurring in these cardiac patients during straining efforts.*



Doxidan is a gentle laxative designed to free your patient from the hemodynamic consequences of straining at stool. With a fecal softening agent to keep the stool soft and easy to evacuate, and with just enough peristaltic stimulation to urge the sluggish bowel, Doxidan reduces the hemodynamic "bind" of constipation.

Composition: Each capsule contains 50 mg. danthron N.F. and 60 mg. dioctyl calcium sulfosuccinate.

Dosage: Adults and children over 12—one or two capsules daily. Children 6 to 12—one capsule daily. Give at bedtime for two or three days or until bowel movements are normal.

Supplied: Bottles of 30, 100 (FSN 6505-074-3169) and 1000 (FSN 6505-890-1247).

*est, C. H. and Taylor, N. B.: *The Physiological Basis of Medical Practice*, 7th edition, illiams and Wilkins, Baltimore, 1961, p. 480.

DOXIDAN®

HOECHST
PHARMACEUTICAL CO.
Div. American Hoechst Corp.
Cincinnati, Ohio 45229 U.S.A.

C-124

(Continued from Page 734)

. . . 'Til Leap Year Gives It Twenty-Nine

This decade will pass faster than the decades on either side of it!

It is one day shorter than either the 1960s or the 1980s. It takes no mathematician to figure that one out. This decade's first Leap Year comes in 1972. There's only one to follow before the decade runs out.

February was once the 12th month rather than the 2nd. Also, it once had 30 days. But it fell the victim of two proud Roman rulers for whom months were named. Julius Caesar took one day away from it to add to his July. And the Emperor Augustus took another off to add to his August.

Last Monday was Groundhog day and next Saturday is Valentine, both of religious significance. For Feb. 2nd is Candlemas Day, while Feb. 14th is celebrated in the liturgy as the day on which the priest St. Valentine suffered martyrdom (in the year 270 A. D. under the Roman Emperor Claudius II).

It has taken the better part of a month to make a full inventory of the more significant happenings of the year just past, and medicine glows brightly in array of accomplishments.

Buried in a single paragraph, deep in NASA's report on 1969—"The Year of Apollo"—is what may yet be hailed as a sensational breakthrough in the war on cancer. The National Aeronautics and Space Administration (NASA) puts it this way:

"New knowledge about the structure and behavior of cancer cells was a surprise 1969 research dividend. Researchers at the NASA Langley Research Center, Hampton, Va., developed a microscope technique that permitted time-lapse photographs of cell division mechanisms in healthy and cancerous tissues."

Thirty-five years ago Donald Culross Peattie, author-botanist, wrote a book titled *An Almanac For Moderns,* which some enthusiast hailed as a "current classic." Under the date of Feb. 1st, Peattie wrote:

"Science is a ship afloat upon a wide waste of waters. Less than Columbus does it know where the world is bound. It does not even know from what port we have set out.

"These thoughts inspire the landlubber with terror. He begs to be allowed to dream that he knows what lies ahead. But for those whom William James called the 'tough-minded,' by which he really meant the stout-hearted, the search itself is the thing, the shore is perhaps but an illusion.

"The beauty, the rightness, the excitement of the search are facts which even the humblest naturalist understands, though he has never done anything more than pursue an unknown bird in the woods for half a day, or climb an alp to find a saxifrage."

In which thought, if you search it out, is a message for medicine.

Will Doctors or Others Blueprint Tomorrow's Medical Care?

In the bumbling 1930's, while a nation shivered and starved, every third pig was being destroyed, food crops were being plowed under, cotton planting sharply curtailed. In Baldwin County a potato crop was piled high and burned.

There was no way to get these items from where they were in overabundance to where they were needed most. Transportation and distribution had broken down.

Today, when medicine is in the mainstream of technological developments that influence social changes—as newer diagnostic and therapeutic techniques serve to rapidly esca-

late medical responsibilities—health care becomes a major distribution problem.

In a recent editorial in *New York Medicine,* Edward A. Burkhardt, M. D., president of the Medical Society of the County of New York, put his finger on one area of responsibility:

"We must face the fact that we are not graduating a sufficient number of new physicians to keep pace with our population growth. We are obligated to train vast numbers of specialty paramedical personnel to free us from routine procedures that demand much of our time.

"Organized medicine (especially the AMA committees) is studying the enormous challenges confronting our profession. The large county medical societies, with infinite resources at their command, have added responsibilities to develop programs that are acceptable to physicians and large rational segments of our citizens. Members of The Medical Society of the County of New York have had the patients and the dispensers of medical care. Today's events force us to accelerate our activities to cope with the ever increasing pressures confronting us. . ."

And then he concludes with a question: "Where will medicine be ten years from now? We are vastly more equipped to blueprint medical care in the future than politicians, lawyers, social workers and economists."

Think about it.

Oldest Known Chimp Is 46

The oldest known captive chimpanzee is Wendy, a member of the animal colony of the Yerkes Regional Primate Research Center (of Emory University) and its predecessors for more than four decades.

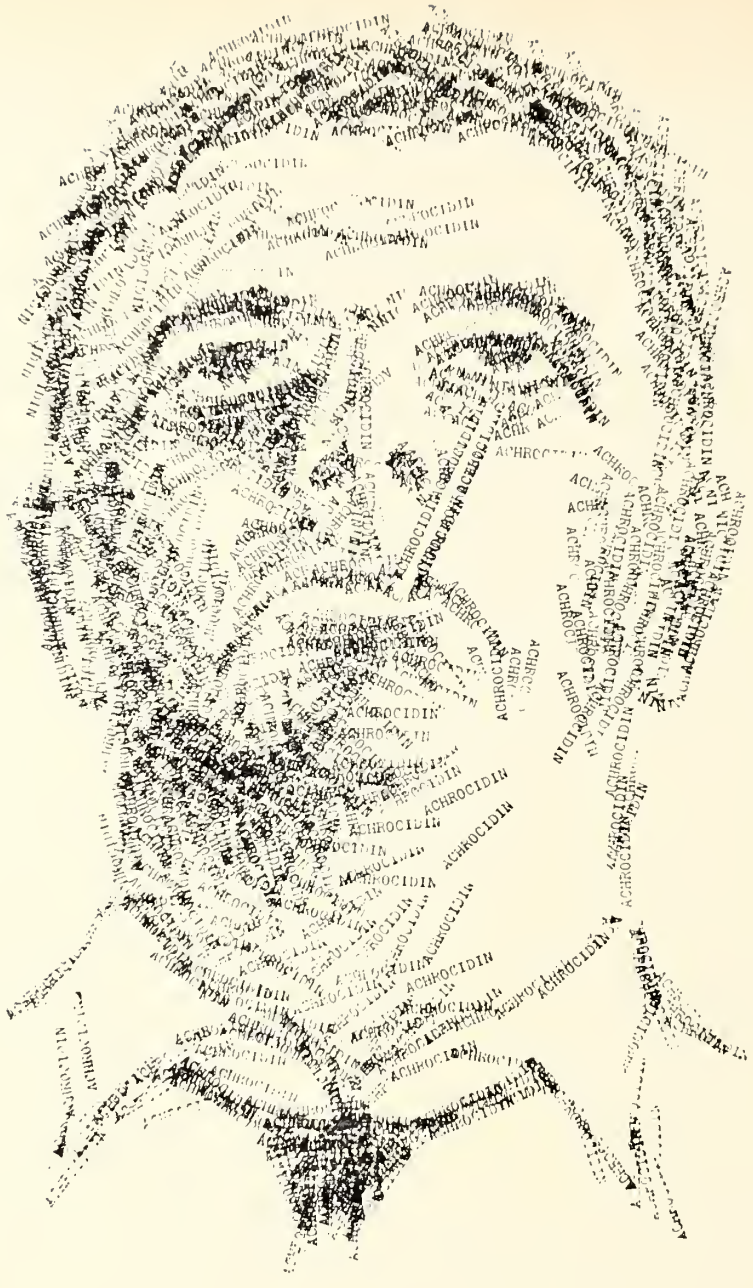
An estimated 46 years old, Wendy behaves rather like an elderly person, according to her keepers. She moves more slowly than the younger animals and is less aggressive and less excitable. However, Wendy is reported to be in good general health and weighs about 117 pounds.

Wendy was born in July 1923 or thereabouts. She was brought from West Africa to the United States by a ship's officer who had picked up two young chimps, a male and female. According to reports, the officer was so fed up with taking care of the apes that by the time his ship reached Boston he was glad to sell them for $500.

Named Pan and Wendy after the Peter Pan characters, the two chimpanzees became a part of the original group of four chimps studied by the late Dr. Robert M. Yerkes of Yale University. They were kept at Dr. Yerkes' primate laboratory, initially on a farm in New Hampshire and later in New Haven, Connecticut. In 1930 the Yerkes animals were transferred to Orange Park, Florida and in the summer of 1965 they were brought to new facilities on the campus of Emory University in suburban Atlanta.

Wendy is the only one of the four original Yerkes chimpanzees still alive. She has had 11 offspring. Five of her grandchildren and three great-grandchildren are members of the present Yerkes collection. Other longtime Yerkes residents (in addition to Wendy) are Soda, who has been with the lab since 1930; Gamma, born in 1932; and Helene, born in 1933.

"These animals have contributed greatly to research in the non-human primate but are on no active programs at this time," says Dr. Michale E. Keeling, Yerkes veterinarian. "They will provide valuable information concerning expected longevity of the laboratory-reared chimpanzee and on geriatric conditions and diseases."



Achrocidin® Tablets and Syrup

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen Citrate 25 mg.

ACHROCIDIN Tetracycline HCl—Antihistamine—Analgesic Compound Tablets and Syrup are recommended for the treatme of tetracycline-sensitive bacterial infection which may complicate vasomotor rhinitis, sinusitis and other allergic diseases of t upper respiratory tract, and for the concomitant symptomatic relief of headache and nasal congestion. For children and elder patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN Tetracycline equivalent Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 m

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliat dermatitis; photosensitivity; onycholysis, discoloration. *Kidney*—dose-related rise BUN. *Hypersensitivity reactions*—urticar angioneurotic edema, anaphylaxis. *Intracra* —bulging fontanels in young infants. *Teet* yellow-brown staining; enamel hypoplas *Blood*—anemia, thrombocytopenic purpu neutropenia, eosinophilia. *Liver*—cholestasis high dosage.

Upon adverse reaction, stop medication a treat appropriately.

Legal Page:

Taxation And The Professional Corporation

J. Jerry Wood, J. D.

Many professional journal articles have suggested corporate forms of practice for professionals. Many articles have warned of the possible tax consequences and disadvantages in spite of the district court victories for several taxpayers.

Recently, in Jerome J. Roubik (53, T. C., No. 36) the tax court refused to recognize for federal tax purposes a professional corporation organized under Wisconsin law, because it did not operate like a corporation. The court said that it would not recognize for tax purposes a "paper" corporation.

In the subject case, four unrelated and geographically separate radiologists organized a professional corporation in accordance with Wisconsin law. However, these physicians continued to operate exactly as they had in their separate private practices and hospital jobs, under their own individual names. Fees and expenses were put through the corporation checking accounts. The corporation elected pseudo-corporation tax treatment and set up an employee pension plan. Each doctor-shareholder was credited with his professional earnings and charged with his expenses. The net for each physician, less his salary, was shown as his taxable income from the pseudo corporation (Subchapter S of the IRS Regulations).

The court found that the radiologists in this case retained control of the performance of their individual patient services and were not bona fide corporation employees. The corporation, therefore, did not earn the income generated by their services. "In the case of a corporation which provides personal services for a fee, income is 'earned' by the corporation or by the person who actually performs the services, whoever has the ultimate direction and control over the earning of the compensation'."

The court focused on the purely "paper" nature of this incorporation. The court said "we know of no case which has decided that two or more professionals engaged separately in their own practices can become, in respect of the income from those practices, 'employees' of a corporation through the purely formal device of incorporating a set of bookkeeping sheets." This case probably indicates a continuing close scrutiny by the Treasury Department of professional corporations. No doubt, the Treasury will attack those corporations which do not act like corporations and do not "control" their earnings.

Some important factors which will support the corporation form of operation are: common premises; ownership of equipment and supplies; common employees (other than the professionals); identification by corporation name, such as the ABC Clinic; patient and client notification of the corporation form; compensation agreements with the corporation; corporation determination of employee assignments; etc.

Even prior to the official approval of professional corporations, the Treasury Department had begun to attack corporations primarily engaged in furnishing the personal services of their stockholder-employees. Most of these were in the entertainment field. However, this same kind of attack can be extended to professional corporations. The Treasury Department will continue to attack any professional corporation it considers to be "paper" or "a sham" to avoid taxes.



The Month in Washington

From the Washington Office
American Medical Association

Washington—The Internal Revenue Service postponed until next January 1 one provision of a new requirement that health insurance companies report to the IRS payments of $600 or more a year to a physician.

The delayed provision covers payments other than under medicare and medicaid. Payments of $600 or more under these government programs must be reported to the IRS. A spokesman said the reporting of payments other than under the government programs was delayed for a year to allow further time for working out compliance procedures.

The IRS regulation applies only to direct payments to physicians. The Senate added an amendment to an omnibus tax bill that would have extended the requirement to indirect payments also. But House-Senate conferees took out the amendment.

Another provision unfavorable to physicians was knocked out of the tax bill, but a third was retained.

The Senate rejected a proposal that would have restricted the tax advantages gained by physicians who organize professional corporations under state laws to establish retirement plans. The Senate Finance Committee had added an amendment that would have set an annual limit of $2,500 per individual, the same as specified under the so-called Keogh law. But the Senate, by a vote of 65-25, knocked out the amendment, leaving physicians, lawyers, engineers and other members of professional corporations able to set aside as much of their income for retirement as they choose.

As finally passed by Congress, the measure includes a provision putting congressional approval on an IRS ruling that advertising revenue of medical and other non-profit, tax-exempt organizations is subject to the regular corporate income tax. Journals of state medical societies, as well as the Journal of the American Medical Association, are affected.

* * *

Medicare's Part B premium partially covering physicians' fees will go up from $4 to $5.30 a month next July 1.

Health, Education and Welfare Secretary Robert H. Finch blamed his predecessor in the post, Wilbur J. Cohen, for the size of the 32 per cent increase in the premium which is matched by the federal government.

Finch noted that the present $4 premium rate, set in December 1968, was too low to cover costs during the current premium period and that the special Medical Insurance Trust Fund has been drawing on its reserves. He said that failure to increase the premium rate last December, in accordance with advice from Social Security Administration actuaries had made it necessary now, in effect, to promulgate two increases at once. Moreover, the depletion of the trust fund that has occurred because of the inadequate rate had made it necessary, he said, to provide for a somewhat higher margin of contingency than would otherwise be necessary.

About half the increase, 64 cents, was needed to finance the program at the level of current operations. The other 66 cents of the $1.30 increase was distributed:

—26 cents to cover an estimated increase of about 6 per cent in the level of physicians' fees;

(Continued on Page 745)

Because any urologic infection can be serious, BREON introduces potent therapy

for the strong start and a fast finish...

"...a significant gap appears to have been closed in the armory of drugs available to the urologist."[1]
Bacteriuria and symptoms can be eliminated within 48 to 72 hours; susceptible infection often in 10 to 14 days.

before your "minor" becomes a major problem

choice initial treatment for urinary infections

Cybis® (nalidixic acid) provides prompt broad gram-negative bactericidal activity at normal urinary pH range that can eradicate troublesome *E. coli,* Aerobacter and Proteus. A good starting drug, it can effectively accelerate management of infection due to sensitive organisms.

essential control within the primary 72-hour cycle

In cases of acute infection due to susceptible organisms, Cybis works well toward the rapid clearing of disease when obstruction is absent or can be relieved. Within 48 to 72 hours, symptoms are frequently eased and bacteriuria eliminated. Susceptible infection is often eradicated in 10 to 14 days.

blocks the young female progression of infection

Cybis can be useful in naturally susceptible young female patients with new or well-established urinary disturbances. Combining rapid potency with relative freedom of serious side reactions and toxicity, the drug can be of particular value in preventing higher tract involvement or blocking the possible continuum of disease. (See Chart)

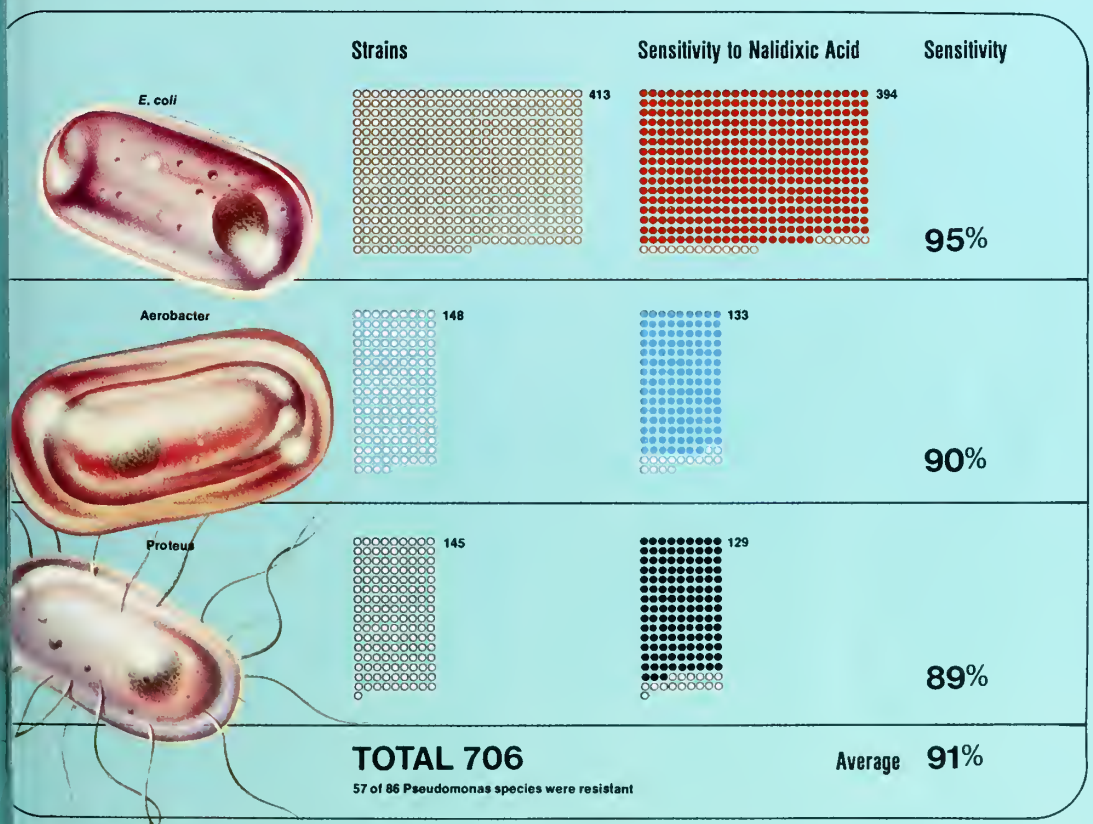
Kinetic Relationship of Acute and Chronic Bacterial Pyelonephritis to Chronic Renal Disease[2]



consistent activity against 706 gram-negative strains

In vitro testing of *E. coli*, Aerobacter and Proteus species showed better than 90% sensitivity to nalidixic acid.[3] (See Table)

Better Than 90% Sensitivity Among 3 Common Urinary Invaders



References: 1. Reimann-Hunziker, R. and Reimann-Hunziker, G. J.: *Praxis 53*:15, Jan. 9, 1964. 2. Sanford, J. P.: *Med. Times 96*:715, July 1968. 3. Reese, L.: *Canad. M. A. J. 92*:394-397, Feb. 20, 1965.

Cybis®
(nalidixic acid)

for the strong start and a fast finish... in cystitis, pyelonephritis, prostatitis, urethritis

Before prescribing, please consult complete product information, a summary of which follows on the next page, including indications, warning, precautions, adverse reactions and dosage.

Summary of prescribing information

Indications: Urinary tract infections in which species of sensitive gram-negative bacteria are predominant, particularly *Proteus, Escherichia coli, Aerobacter, Klebsiella,* and certain strains of *Pseudomonas.* Gram-positive bacteria are less sensitive to Cybis but favorable clinical results have been observed.

Warning: Use in Pregnancy. This drug is not recommended in the first trimester of pregnancy. However, it has been used in several patients during the last two trimesters without producing apparent ill effects in either mother or fetus.

Precautions: Although prolonged treatment with Cybis has been generally well tolerated, as with all new drugs it is advisable to carry out blood, renal, and liver function tests periodically if treatment is continued for more than one or two weeks. The dosage recommended for adults and children should not be arbitrarily doubled unless under the careful supervision of a physician. **It should be used with caution in patients with liver disease, epilepsy, or severe cerebral arteriosclerosis, and in patients in whom kidney function is severely impaired.** Patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving Cybis and, if a photosensitivity reaction occurs, therapy should be discontinued.

During treatment microorganisms may develop resistance to this drug. Resistant bacteria, not previously present or identified, may emerge. Cultures should be taken and bacterial sensitivity tests made periodically, particularly if the clinical response is unsatisfactory or if a relapse occurs. Should resistance develop, other specific chemotherapy should be instituted; no cross resistance has been observed. If new strains of bacteria that are not sensitive emerge, other effective antibacterial agents may be added. When Benedict's or Fehling's solutions or Clinitest® Reagent Tablets are used to test the urine of patients taking Cybis, a false-positive reaction for glucose may be obtained due to the liberation of glucuronic acid from the metabolites excreted. However, a colorimetric test for glucose based on an enzyme reaction (using, for example, Clinistix® Reagent Strips or Tes-Tape®) does not give a false-positive reaction to Cybis glucuronide.

Adverse reactions: Mainly mild nausea, vomiting, and other gastrointestinal disturbances: less frequently, sleepiness, drowsiness, weakness, headache, dizziness and vertigo, and rarely cholestasis, paresthesia, thrombocytopenia, leukopenia, or hemolytic anemia which in some patients may have been associated with deficiency in activity of glucose-6-phosphate dehydrogenase. Itching, pruritus, rash, urticaria, mild eosinophilia, reversible photosensitivity reactions primarily involving exposed surfaces, and reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), occurred occasionally. Reversible increased intracranial pressure with bulging anterior fontanel, papilledema, and headache have been observed occasionally in infants and children. Toxic psychosis and brief convulsions (the latter generally in patients with possible predisposing factors, and both usually associated with excessive dosage) have been recorded in rare instances.

Dosage and administration: *Adults*—Four Gm. daily by mouth (2 tablets of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily (1 tablet of 500 mg. four times daily). *Children*—According to age and weight: approximately *25 mg. per pound* of body weight per day, administered in divided doses.

Note: The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied: Tablets of 500 mg., bottles of 50.

Before prescribing, please refer to complete prescribing information.

Cybis®

(nalidixic acid)

for the strong start and a fast finish...

in cystitis
pyelonephritis
prostatitis
urethritis



BREON

BREON LABORATORIES INC.
90 Park Avenue, New York. N.Y. 10016
Subsidiary of Sterling Drug Inc.

(Continued from Page 740)

—about 12 cents to cover an estimated increase of 2 per cent in the utilization of services under the program;

—about 6 cents because the $50 deductible which a patient pays will be a smaller proportion of the total covered charges;

—the remaining 22 cents to provide a 4 per cent margin for contingencies.

* * *

President Nixon signed into law legislation setting tough federal safety standards for coal mines.

Although he had reservations about a conflict with state workmen's compensation laws, Nixon said "the health and safety provisions of this act represent an historic advance in industrial practices." He also cautioned that this law should in no way "be considered a precedent for future federal administration of workmen's compensation programs."

The Secretary of Health, Education and Welfare was given for the first time authority to set health standards for mines. Nixon said he had asked that wherever possible the disability standards under the new act be consistent with those of the Social Security disability program.

Pressure for the legislation started building up after 78 died in a Mannington, West Virginia mine disaster last November.

The AMA supported an overall Administration bill on occupational health and safety, and pledged the backing of the nation's physicians for any program "well designed to improve the safety and health of the American worker."

Dr. R. Lomax Wells, Silver Spring, Maryland, immediate past chairman of the AMA's Council on Occupational Health, told a Senate labor subcommittee:

". . . the American Medical Association supports the new Administration bill, S. 2788. Its provisions for standard setting, not in the Labor Department but in a new National Occupational Safety and Health Board appointed by the President, with a majority of professional experts, seems to us an acceptable equivalent to our previous suggestion of a National Council on Hazardous Physical and Chemical Agents. We endorse its concept of a separation of powers between standard setting and enforcement. We welcome, in this new bill, the intent to give a larger role to the Department of Health, Education and Welfare, whose competence in this field is recognized. Our Association approves the provision for federal support of state occupational safety and health programs to supplement inadequate manpower in the federal system. We believe that this emphasis on support of the state programs, combined with standard setting by an independent professional Board, is greatly preferable to mandatory national standards promulgated and enforced by a single federal agency. In this regard, we welcome the stress on the use of consensus standards, and provisions for consultation with professional standard-setting agencies before establishing needed new standards."

A National Heart and Lung Institute task force predicted that the demand for heart transplants will increase beyond the present level of about 100 a year and exceed the number of the organs available for the operation.

The report of the task force on cardiac replacement also said:

—Less than 16 per cent of the 200,000 Americans under 65 who die each year from heart disease are good candidates for transplants.

—Rejection of the transplanted heart will remain "the greatest barrier to prolonged survival."

—Development of an artificial heart is now a distinct possibility.

—The federal government should emphasize research on the prevention, early detection and early treatment of heart disease.

—A new definition of death is needed.

—Total transplant charges for 36 patients averaged $18,694 per patient.

—Heart transplants have been performed on 148 patients, with 23 persons still surviving, 16 of them in the United States.

—More than 32,000 heart disease victims can be considered transplant candidates, but there are only about 22,000 possible donors a year, the report said.

* * *

The Food and Drug Administration was reorganized and given independent status under a new commissioner.

The reorganization followed several years of criticism of the Health, Education and Welfare Department agency from all sides—Congress, industry and consumers' groups. The criticism resulted in a two-month study by a task force headed by HEW Deputy Assistant Secretary for Welfare Fred Malek.

The reorganization focused on FDA's structural problems and the chief aim of HEW Secretary Robert H. Finch appeared to be to get the agency operating more efficiently. FDA was taken out of the Consumer Protection and Environmental Health Service and placed in the department's staff structure on an equal basis with the remaining Environmental Health Service and the National Institutes of Health.

Dr. Charles C. Edwards, 46, formerly a division director on the American Medical Association headquarters staff, was named to replace Dr. Herbert L. Ley, Jr., as head of the FDA. Ley was offered another post in HEW but declined it. Two of Ley's top aides, FDA Deputy Commissioner Winton B. Rankin and Associate Commissioner for Compliance J. Kenneth Kirk, were transferred from the agency.

Edwards was praised by a former associate on the AMA staff, C. Joseph Stetler, president of the Pharmaceutical Association, as being highly qualified by his scientific and administrative background.

The new FDA head said he would bring "hard-nosed management principles" to the agency and work more closely with industry, but that his administration of FDA would be oriented to the consumer. He said his decisions as a government official will not be influenced by his former association with the AMA.

Not just a motel
it's a Guest House

. . . with 171 handsome rooms designed for your comfort and convenience. A center-of-everything location including Birmingham's University of Alabama Medical Center . . . making The Guest House a favorite of Doctor's wives and in-town outpatients. Superb dining, dancing and nightly entertainment. Come stay with us often.

THE RESTAURANT
THE PLAYROOM • CYPRESS ROOM
CONVENTION FACILITIES



The Guest House
MOTOR INN

PHONE 324-8653
18TH ST. &
10TH AVE., SOUTH
BIRMINGHAM, ALABAMA

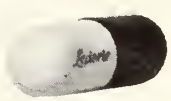
"Where the Action Is!"

Doctor, after all we've been through together...

abscess
aene
amebiasis
anthrax
baeillary dysentery
bartonellosis
bronehitis
bronehopulmonary infeetion
brueellosis
ehaneroid
diphtheria
endocarditis
genitourinary infeetions
gonorrhea
granuloma inguinale
listeriosis
lymphogranuloma
mixed baeterial infection
osteomyelitis
otitis
pertussis
pharyngitis
pneumonia
psittacosis
pyelonephritis
Roeky Mountain spotted fever
searlet fever
septieemias
sinusitis
soft tissue infeetion
tonsillitis
tularemia
typhus fever
urethritis

...don't you think it's time we were on a first-name basis?

call me "Achro® V"



Every pharmacist knows ACHRO® V stands for ACHROMYCIN® V

traindications: Hypersensitivity to
ieyeline.
ning: In renal impairment, sinee
toxicity is possible, lower doses
ndieated; during prolonged therapy
ider serum level determinations.
todynamie reaetion to sunlight may
ir in hypersensitive persons.
tosensitive individuals should
d exposure; diseontinue treatmcnt
in discomfort oecurs.
autions: Nonsuseeptible organisms may overgrow; treat superinfeetion appropriately. Tetracycline may form a stable caleium eomplex in bone-forming tissue and may eause dental staining during tooth development (last half of pregnaney, neonatal period, infaney, early ehildhood).
Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enteroeolitis, pruritus ani. *Skin*—maeulopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onyeholysis, nail diseoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urtiearia, angioneurotie edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—eholestasis at high dosage. Upon adverse reaetion, stop medication and treat appropriately.

Achromycin® V
Tetracycline

Lederle LEDERLE LABORATORIES • A Division of American Cyanamid Company, Pearl River, New York 10965

484-9


Each 5 cc. contain erythromycin estolate equivalent to 250 mg. erythromycin base.
When mixed as directed, each 5 cc. will contain erythromycin estolate equivalent to 125 mg. erythromycin base.
When mixed as directed, each cc. will contain erythromycin estolate equivalent to 100 mg. erythromycin base.
Each 5 cc. contain erythromycin estolate equivalent to 125 mg. erythromycin base.
Each tablet contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule® contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule contains erythromycin estolate equivalent to 250 mg. erythromycin base.
The many forms of Ilosone®
Erythromycin Estolate
Lilly
Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206
900761

THE JOURNAL

of

THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

Published Under the Auspices of the Board of Censors

Volume 39 February, 1970 No. 8

Early Recognition And Prompt Evaluation Of Spinal Deformity

By Walter P. Blount, M. D.

Milwaukee, Wisconsin

The Milwaukee Brace is generally accepted by orthopaedic surgeons as the first appliance in medical history to correct thoracic scolioses in growing children without operation.[1] Its effectiveness in improving a moderately severe curvature is shown in Figure 1. The cooperative girl with a skeletal age of 14 with poor posture, a curve of 50°, and the trunk shifted to the right can be given a back that looks straight with excellent posture and enduring normal function. Specific exercises[2] in a well made brace are capable of correcting considerably greater curves if the patient is still growing.

The result is still better if she appears for treatment at 13 with a 25° curve. My crusade this year as expressed in the title is for the early recognition and prompt evaluation of these deformities with prompt referral for treatment at the optimum age.

A girl with a skeletal age of more than 15 will improve her posture and appearance with such treatment but will obtain little permanent correction of the lateral curvature. The upper limit for boys is two years older.

The cooperative effort of the orthopaedic surgeons, orthotists, and other paramedical workers of Milwaukee has produced a valuable medical tool (Fig 1 B) that has been improved over the past 15 years by suggestions from orthopaedic teams from Minneapolis to Helsinki. The 1969 brace is not only efficient but more comfortable and inconspicuous (Fig 2). Orthotists have learned to make good braces and orthopaedic surgeons, to use them. The greatest difficulty at this point is that the patients are often referred for treatment a year or more too late to obtain good results.

Unfortunately, the beginning deformity is not noticeable under ordinary clothing. In our modern society adolescent girls are rarely seen in the nude, and significant lateral curves go unnoticed for several years. Occasionally a physician, a school nurse or a gymnasium teacher will pick up an early scoliosis, but for the most part the deform-

---

Abbreviation of paper presented at the 128th Annual Meeting of the State Medical Society of Wisconsin, May 13-15, Milwaukee.

Reprinted from the Wisconsin Medical Journal, August 1969: vol. 68.

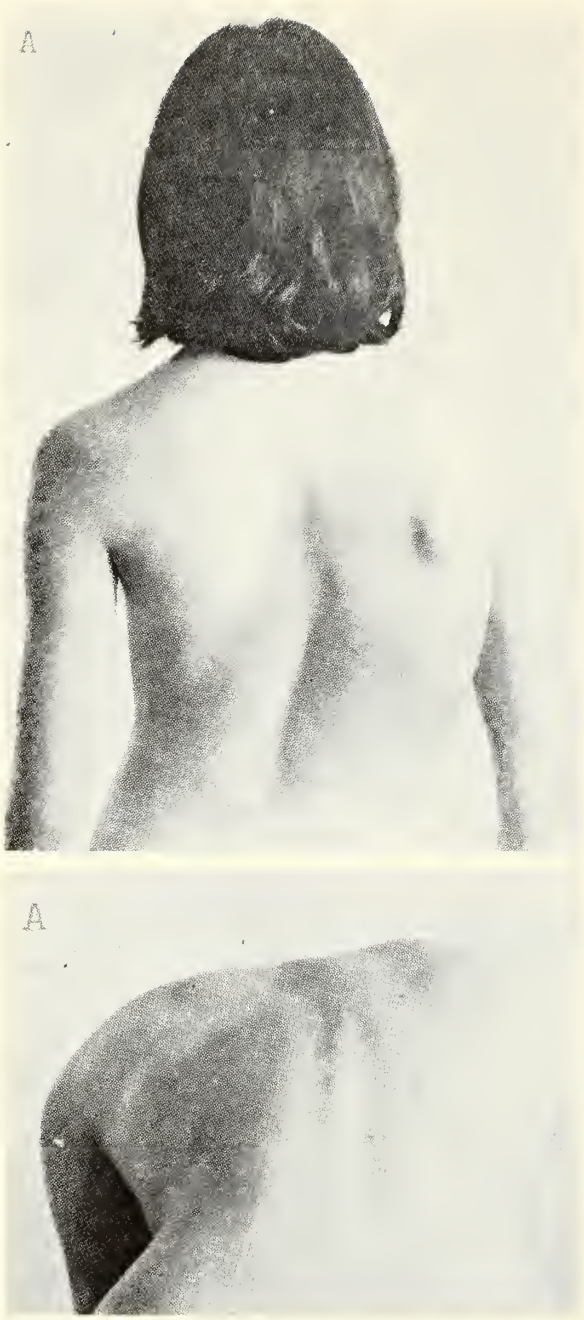


Figure 1 A

Fig. 1A—Skeletal age 14. A right convex thoracic curve with an overhang to the right and a prominence of the scapula and ribs on the right side were noticed only four months before this picture was taken. In the forward bent position the rib prominence was more noticeable.

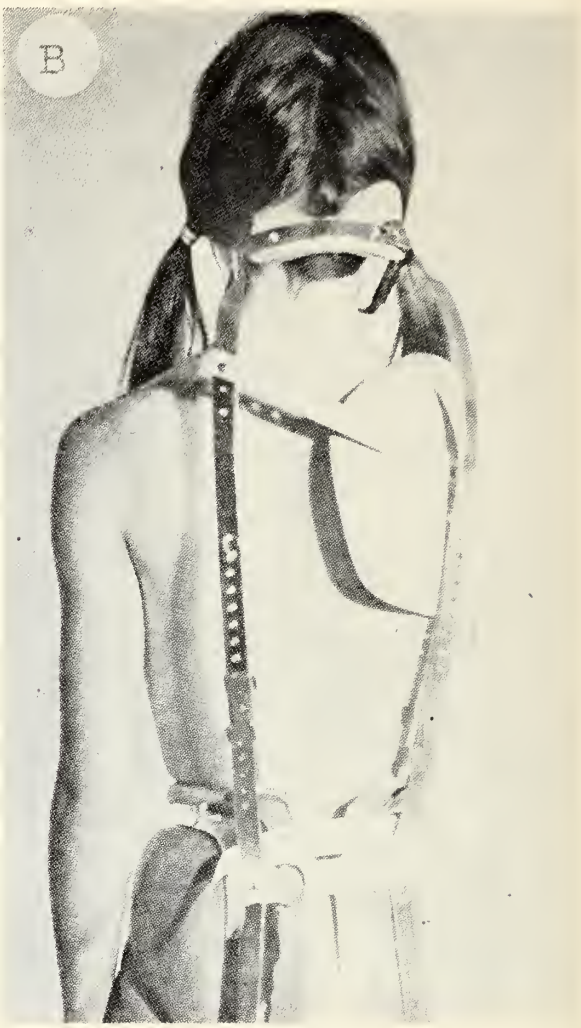


Figure 1 B

Fig. 1B—A Milwaukee brace held the torso in the corrected position.

With exercises in the brace the curvature was repeatedly corrected. The rib hump was diminished and the thoracic valley on the left side was partially filled out. The improved position was maintained by the shoulder pad which provided passive correction for the rib hump when the patient was supine. Gentle distraction was furnished by the occiput pad opposed by a closely molded pelvic girdle.

ities are well developed before they are recognized.

The crusade must start by teaching the mother to look at her daughter or son at regular intervals during the growing years. After the child is inspected while standing, he must bend forward. Slight deviations such as those in Figures 3 and 4 are mini-

mized by wishful thinking to "slight posture habits that will be outgrown." But when the bent back shows a definite rib prominence on one side, the mother is looking at a structural scoliosis. This asymmetry is the early sign of a deformity that is usually rapidly progressive. The child should be taken to the physician immediately. After two years without effective treatment, the deformity may become as bad as that of the unfortunate girl in Figure 5.

The informed physician will recognize the scoliosis by careful inspection particularly with the child in the forward bent position. He will confirm the diagnosis with an x-ray film taken in the standing position or send the child at once to an orthopaedic surgeon.

One difficulty is that the medical fraternity, including some orthopedic surgeons, is too apt to wait and watch these deformities instead of acting promptly.



Figure 2

Fig. 2—The modern brace is streamlined for comfort and efficiency. It is less objectionable to adolescents because it cannot be seen above a turtle neck sweater or a scarf. The girl has obtained a beautiful result with no bite deformity because all of the holding force is on the front of the throat. The modification is a boon to the orthodontist because it frees the jaw completely.

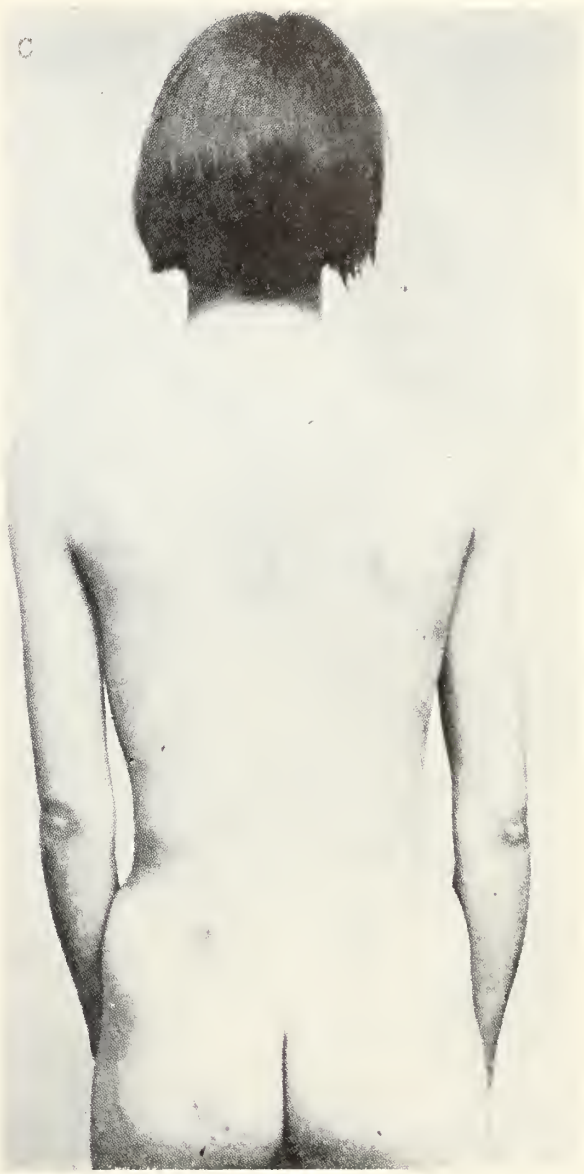


Figure 1 C

Fig. 1C—Three years later, the spine looked straight. The diminished curves were well compensated. The torso was symmetrical except for a slight residual rib hump. There was no loss of mobility and no scar.

Radiologists who read chest and gastrointestinal films should not stop with reporting a lateral curvature. They should push the alarm button. They, too, must join the crusade and notify the pediatrist or the generalist that they have discovered a deformity which will probably be progressive and



Figure 3 A and Figure 4 A

Fig. 3A—Asymmetry of the torso is clearly evident but the mother dismissed it as a postural habit.

Fig. 4A—A prominent hip will be observed in fitting a skirt. It must not be accepted as an individual peculiarity but recognized as the first sign of a vicious deformity which may progress rapidly.

should be evaluated by a medical man who is truly interested in spinal curvatures.

A 10° curve may be innocuous, but the patient must be reexamined at intervals of three months with x-ray views made in a standing position. If there is any doubt about progression, the curves should be measured accurately, preferably by the Cobb technic.[3] Succeeding x-ray films should be compared with the original. A consistent



Figure 3 B and Figure 4 B

Fig. 3B—She should have had the patient bend forward to bring out the rib hump which is the sign of a structural scoliosis.

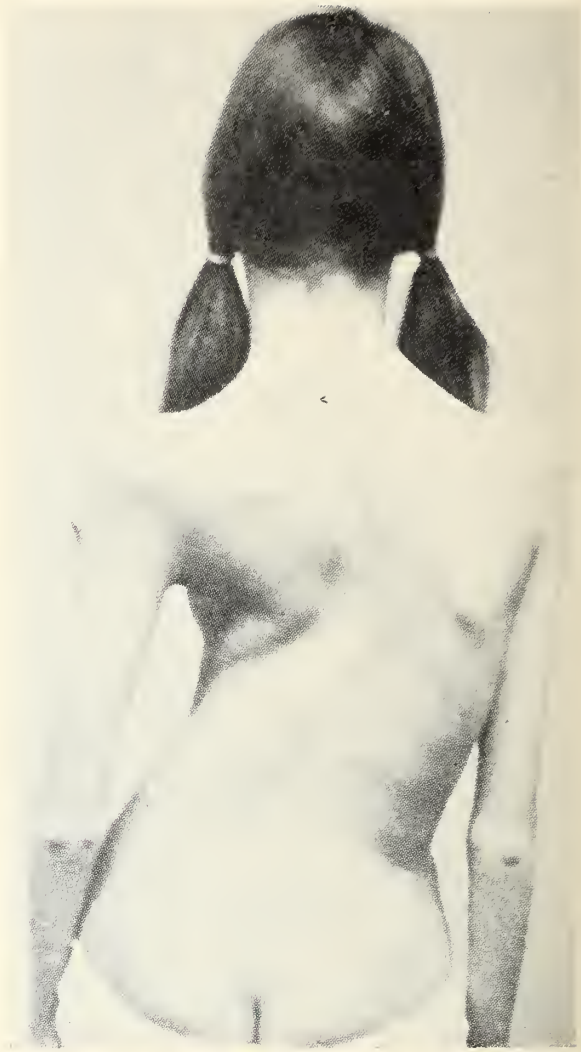


Figure 5

Fig. 5—This child was taken to a chiropractor when the deformity looked like that in Figure 1. Under his "treatment" she became rapidly worse. The credulous mother was satisfied for two years by a consultation with another chiropractor who assured her that the patient was improving. There is good reason why these practitioners are not accredited—but they are good salesmen.

This poor girl required extensive bone surgery with the use of Harrington rods. This treatment could have been avoided had she come to the orthopaedic surgeon when the deformity was first noticed.

←

Fig. 4B—When the child bends forward, the prominence of the transverse processes and the lower ribs on the left side are clear evidence of a structural deformity which may become catastrophic as in Figure 5.

increase of 10° or 15° is an indication for prompt action. At this stage a spine can be straightened completely by the Milwaukee brace and exercises in the brace. There is every advantage and no disadvantage to starting the treatment immediately.

If the child is young and the spine is kept perfectly straight for several months, the patient may be partially weaned from the brace and wear it at night only.[4] There is almost no objection from the child to this routine.

Not only the radiologist but also the pediatrist and the generalist must recognize the urgency of the situation. A delay of six months may mean an increase in the curve of 20° to 30°, some of which will never be regained without an extensive operation. Structural deformity of the vertebral bodies with wedging cannot be completely overcome by any method except during infancy and early childhood.

There is justification for the careful observation of a small curve without treatment. An infantile idiopathic scoliosis may prove to be of the resolving type and disappear spontaneously in a few months. It may, however, be a vicious progressive deformity that proves to be resistant to all treatment except for that with the Milwaukee brace, sometimes combined with bed rest and traction. Occasionally an idiopathic scoliosis in an older child will not progress, but this is the rare exception. Most of them become worse with catastrophic rapidity during adolescent years.

Even congenital scolioses are usually progressive. The unfortunate aphorism that "congenital scolioses do not become worse" arose from the observation of a few curves with hemivertebrae. It is true that some of them remain unchanged over several years

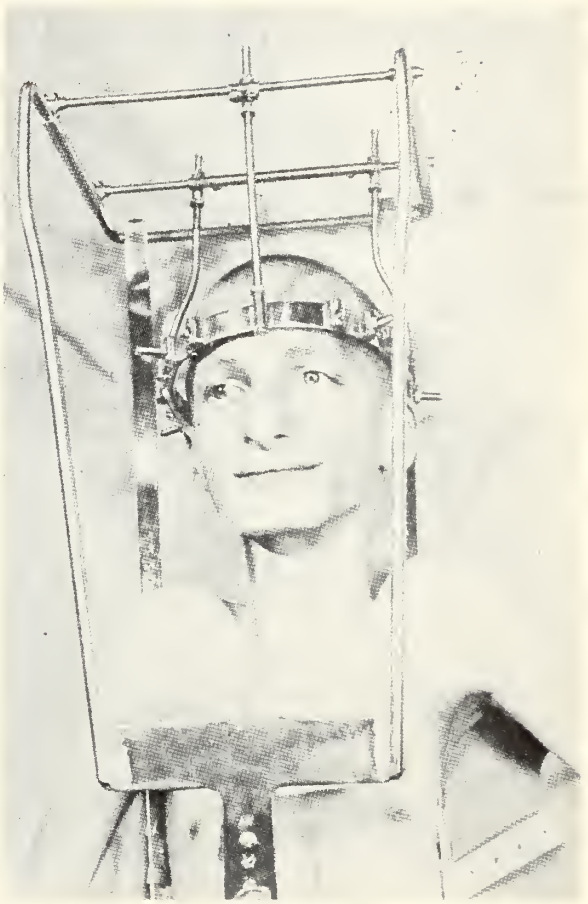


Figure 6

Fig. 6—Modification of the brace by the application of a halo to the upper end and a traction frame to the lower, has helped to solve the most sophisticated problems occasioned by extreme neglected deformities.

of growth, but one has no assurance that the angular deformity will not suddenly start to increase at any time, particularly during adolescence. All spinal curvatures should be carefully followed during the growing years and reexamined at intervals not exceeding six months.

The remarkable thing is that some seemingly rigid deformities can be maintained in an improved position by a Milwaukee brace. This is true particularly of the characteristic scolioses associated with von Recklinghausen's neurofibromatosis, Marfan's disease, and the rarer neuromuscular disorders.

The effective management of the more complicated scoliosis problems requires con-

siderable experience.[5] The principles of treatment have been more clearly understood in the decade following 1958 and the technics have advanced as rapidly as those in heart surgery. Without present excellent anesthesiology and the replacement of lost blood, long segments of the spine can be fused at one sitting. We no longer rely on external fixation alone for postoperative immobilization. Scientifically engineered distraction rods aid in the correction of deformity on the operating table and the postoperative immobilization which is so important in obtaining solid fusion. Neglected curves that jeopardize respiratory function can be greatly improved by skeletal traction on the skull with distraction on the bones of the lower extremities. This sophisticated procedure may be simplified by the use of accessories to the Milwaukee brace (Fig 6). When the fusion is solid, the halo and traction frame are removed and the patient is ambulatory during convalescence in a conventional brace.

The anterior or lateral approach makes it possible to resect vertebral bodies and to graft them. Internal fixation is remarkably effective when applied anteriorly.

But all of these brilliant operative approaches to the problem are only salvage procedures. The best treatment is still the early recognition, prompt evaluation, and nonoperative treatment of the curves with the Milwaukee brace and exercises in the brace. The ultimate result is cosmetically just as good without the risk involved with operation. There is no postoperative stiffness and no scar.

If we are to avoid extensive surgical procedures and obtain the best possible result, we must reach the mothers, the pediatrists, and the generalists. The patients must come to orthopaedic surgeons early when the curvatures are small and the patients are growing. Then they will grow straight in the Milwaukee brace instead of continuing to grow more crooked.

The treatment will not be successful, however, unless the Milwaukee brace is efficient and comfortable. The orthotist who made it must be readily available to modify the brace as the patient grows and the curve patterns change. The orthopaedic surgeon must be well informed and genuinely interested in the nonoperative treatment of scoliosis. The patient must be immature and dedicated to correcting the deformity. The parents must be cooperative and not too permissive.

In recent years we have found that better results are obtained more rapidly when the patient performs specific exercises in the brace under the direction of a specially trained physical therapist.[2] Finally it is important that the patient be examined by an orthodontist at the start of the scoliosis treatment. The modern brace (Fig 2) does not cause any jaw or bite deformity. It is important that a record be made of the condition of the teeth before treatment is begun. The brace should not be blamed for preexisting deformities. Orthodontic treatment that was in progress can be continued while the patient wears the brace.

If these requirements are met and treatment started before the patients are mature, more than 50% of the spinal curves that have previously required operative treatment will improve with the Milwaukee brace and exercises in the brace so that cosmetically acceptable and normally functioning backs are obtained without operation.

Summary

All young children with scolioses of any etiology and particularly adolescents with moderately severe idiopathic curves and Scheuermann's round back should be treated with a Milwaukee brace and exercises in the brace. If good braces are available and treatment is started early, the results will usually be excellent. If parents and physicians learn about this and send patients to well informed orthopaedic surgeons promptly while the curves are still small, opera-

tions will be necessary only for neglected patients and a few stubbornly progressive curves.

References

1. Blount, Walter P.: The Milwaukee brace in nonoperative scoliosis treatment, Acta Orthopaedica Scandinavica 33:399-401, 1963.

2. Blount, Walter P., and Bolinske, Jane: Physical therapy in the nonoperative treatment of scoliosis, Physical Therapy 47:919-925, 1967.

3. Cobb, John R.: Outline for the Study of Scoliosis. Instructional Course Lectures, American Academy of Orthopaedic Surgeons V:261-275, J. W. Edwards, Ann Arbor, 1948.

4. Blount, Walter P.: The Milwaukee brace in the treatment of the young child with scoliosis, Archiv fur Orthopadische und Unfall Chirurgie 56:363-369, 1964.

5. Blount, Walter P. et al: The Milwaukee brace in the operative treatment of scoliosis, J Bone & Joint Surg 40-A:511-528 (June) 1958.

Psychiatry's Mystery

"Psychiatry has been a mystery long enough. College graduates have a right to have some knowledge of this field."

This is the philosophy behind a unique course at Emory University aimed at removing the cloud of stereotypes and lack of information about psychiatry.

An eight-week non-credit course introduces many of Emory's dormitory advisers to psychiatry. The course, similar to that taught to sophomore medical students, deals with "what psychiatrists consider problems, the kinds of people they see, what they have to offer and what they don't have to offer," according to the teacher, Dr. Jack M. Hawkins, assistant professor of psychiatry.

The course includes a one-hour lecture once a week, followed by a one-hour interview of a psychiatric patient. The patients—from an 18-year-old high school dropout to an elderly businessman—often provide graphic illustrations of the types of problems discussed in the lectures.

Currently a pilot program in cooperation with the university's housing office, the course may eventually be opened to all Emory upperclassmen.

There Must Be Some Mistake

Under the above headline, one Ben E. Walker addressed a letter to the Editor of The News Leader, copied in the Virginia Medical Monthly:

I was going through my pockets last night and found something I'm at a loss to explain. A genuine, United States ten dollar bill. Obviously, I've made a mistake and overlooked a tax.

I've paid my income tax, State tax, city tax, surcharge tax, unemployment tax, Social Security tax, personal property tax, real estate tax, sales tax, amusement tax, gasoline tax, road tax and license tax.

I distinctly remember paying the liquor tax, cigarette tax, school tax, utility tax, welfare tax, and I'm positive I've paid my taxes for fire protection, law enforcement, and garbage collection. I've paid my taxes for a line to bring water into my home, and sewer to take it away.

I checked back and found that I have paid my excise tax, luxury tax, defense tax, and even a tax to provide more scholarships for kids to go to college so that they can grow beards, demonstrate, riot, destroy, make fools of college presidents, and protest against idiots like you and me.

I've paid my taxes for the Rockefeller trip, the Godwin trip, plane fare for vacationing Congressmen and publicity for the Birds of Texas.

I'm bewildered as to how this ten dollar bill got into my pocket. Did someone put it there, just to cause me trouble? Is there a tax when you suddenly discover money like this? I'm not really sure, but I believe I'll keep it hidden until it becomes time to pay my tax for registering my gun that I have to keep in my home for the protection of my wife and kids.

Please keep this whole thing confidential for I am certain the government will be plenty sore if they find out that I have it.

Pulmonary Function Testing For The General Hospital And Physician

D. S. Tysinger, Jr., M. D.
Dothan, Alabama

Part III—An Introduction to Pulmonary Function Testing

There are several factors to be considered if one is to understand pulmonary function testing. As a quantity of gas gets warmer it expands and occupies a larger volume; as it cools it tends to shrink. In order to saturate a gas at a high temperature a greater volume of water is required. If a gas is saturated with water at a high temperature and the temperature then falls, the water will be "rained" out. In measuring gases by volume we must consider that we are working with gases at different temperatures. The average room temperature is about 72 degrees F., and average body temperature is 98.6 degrees. This means that a volume of air that is expelled, and cools on being expelled, from the body into a measuring container at room temperature will decrease to some extent in volume and water content. All gas in the lungs and in the body that is expelled from the lungs during function testing is 100 per cent saturated with moisture at body temperature which means it will be more than super-saturated at room temperature and there will be some loss of moisture due to condensation. Accordingly, the volume of gas one measures at room temperature would be different from the gas that actually was expelled by the body. If one actually measures five liters at room temperature and then mathematically converts it back to body temperature and saturation, one would find that it is now 375.5 ccs. larger than was actually measured. Therefore, gases are measured as being at Body Temperature and Pressure Saturated, which is actually what it is in the body, or can be recorded at Room Temperature and Pressure Saturated. This latter is known as Ambient Temperature and Pressure Saturated. There are also some studies that require strict corrections which are converted to Standard Temperature and Pressure Dry. This is 760 mms. of mercury pressure, 0 degrees centigrade dry gas. Thus in doing a function study, it is necessary to state whether this study is done at body temperature pressure saturated (BTPS), at room temperature and pressure saturated (known as ambient temperature and pressure saturated or ATPS), or standard temperature and pressure dry (STPD). There are tables obtainable for the common pulmonary function tests that are made up for BTPS, ATPS, or STPD. The ATPS tables will differ and be smaller in amount than the BTPS tables.

The next factors one needs to understand are the lung components and volumes. The total amount of air the lungs will hold, or total lung capacity is made up of several subdivisions. These will be reviewed. In Diagram 9A is represented the total amount of air the lung will hold. If this is represented as a block then this is the total lung capacity (TLC). At B, in the middle of this area, is the normal exchange of air from inspiration to expiration as one breathes. It is in the middle portion and is known as tidal volume (TV) 9B. Between this tidal volume and the total amount of air that can be taken in or total lung capacity, there is a volume that can still be taken in after a normal inspiration 9B. If it is measured from the top of the tidal volume to the total lung capacity it is known as the inspiratory reserve volume (IRV). If the tidal volume is added to the

This is the third in a series of seven articles.

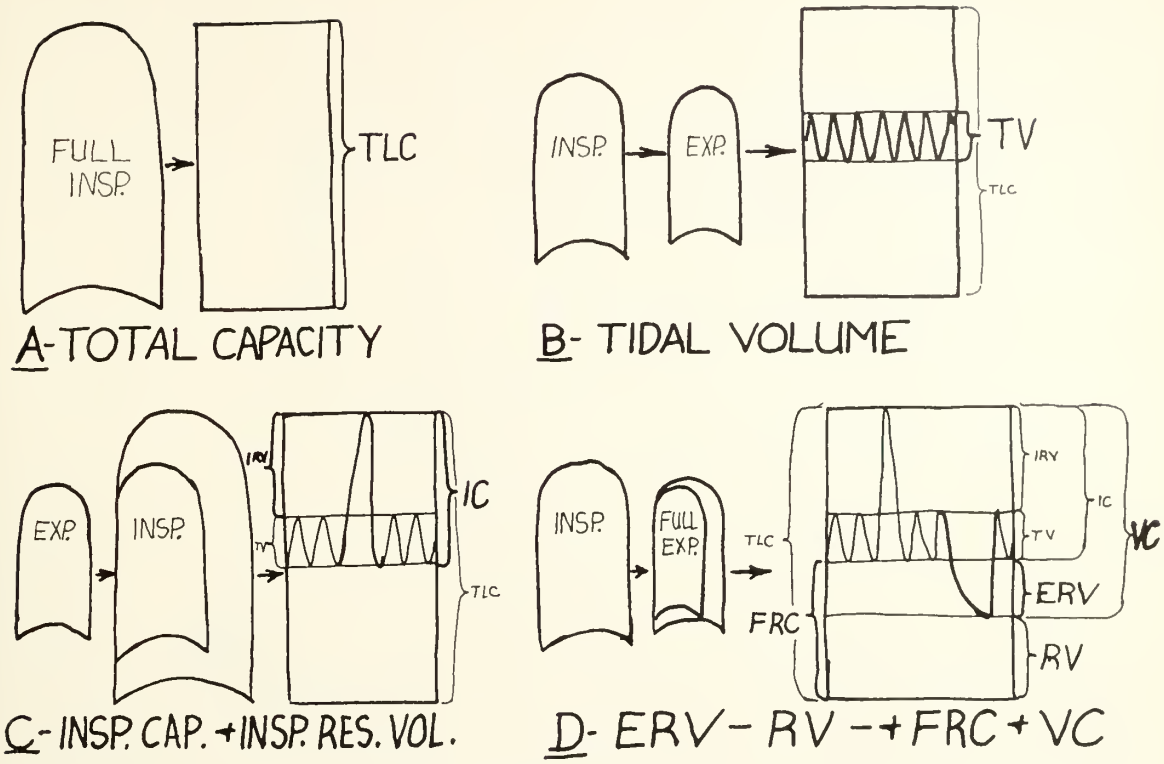


Diagram No. 9

inspiratory reserve volume the result is a capacity known as the inspiratory capacity. (IC). From the resting chest cage position, at the end of the tidal volume, there can be expelled a volume of air until the maximum reduction in chest cage volume has occurred 9D. This is all the air that can be blown out of the lungs and this volume is known as the expiratory reserve volume (ERV). That amount of air remaining in the lungs that cannot be expelled and which always stays in the lungs is known as the residual volume (RV). The amount that can be blown out of the lungs from maximum inspiration to maximum expiration, then, includes inspiratory reserve volume, tidal volume, and expiratory reserved volume. This total volume is known as the vital capacity (VC). In normal breathing the chest cage does not collapse maximally. Therefore, that amount of air remaining in the lungs at the end of a normal expiration when breathing a normal tidal volume includes both the expiratory reserve volume and the residual volume. This amount is spoken of as the functional residual capacity (FRC). This is the actual amount of air that normally remains in the lungs. Normal breathing must mix with this amount known as interpulmonary mixing. If all of these volumes are added together—inspiratory volume, tidal volume, expiratory reserve volume, residual volume—they add up to the total amount of air the lungs will hold or the total lung capacity. In pulmonary function testing these can be measured and indeed the relation of each to the other is quite important. As a rule the vital capacity is divided into inspiratory capacity and expiratory reserve volume. These should be about 75 per cent for the inspiratory capacity and about 25 per cent for the expiratory reserve volume. As obstructive and other diseases occur, the tidal volume is moved to a higher position because of the resistance to normal collapse by the disease process itself (D factor). The tidal volume usually becomes larger. The inspiratory capacity becomes smaller and, therefore, the expiratory reserve volume becomes larger. As was discussed in a previous section—"Abnormal

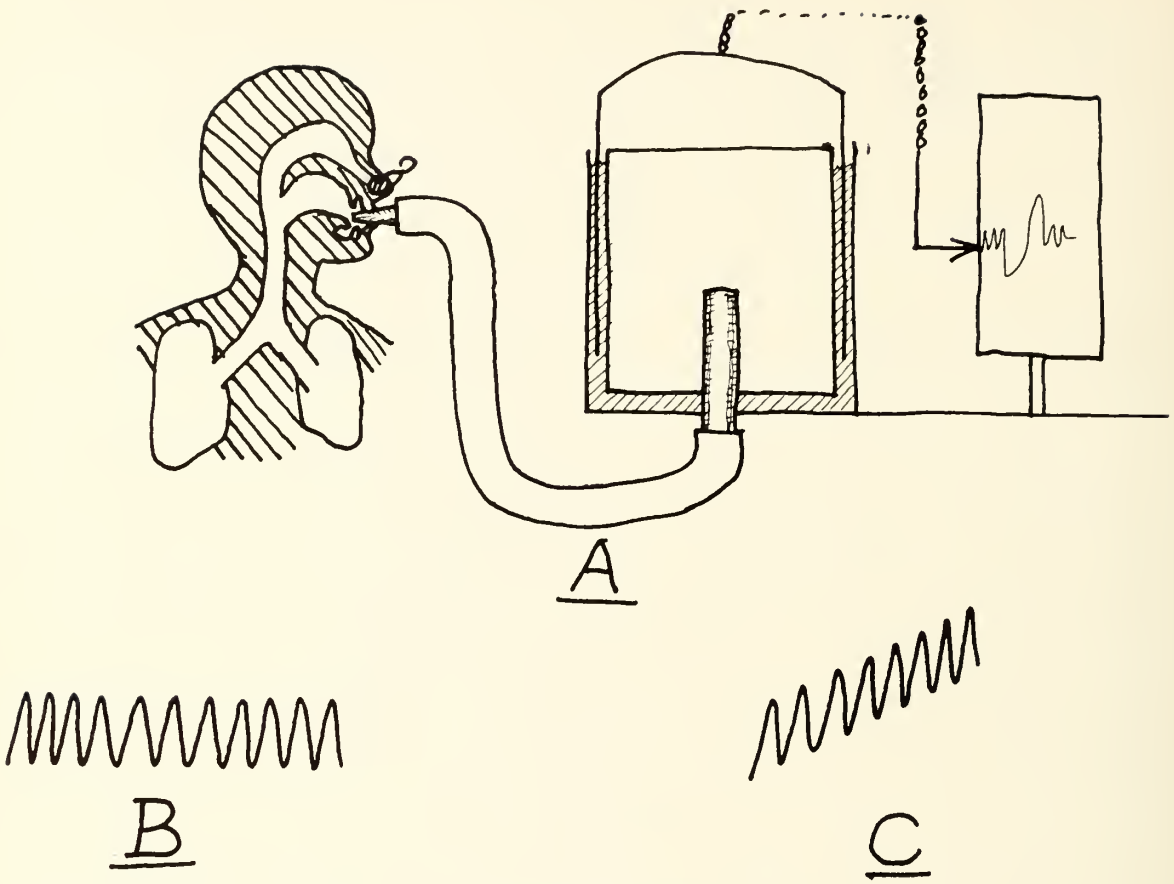


Diagram No. 10

Physiology"—the tidal volume must be sufficient to carry adequate amounts of air to the functioning pulmonary units regardless of how much air has to be used to fill non-functioning pulmonary units. Therefore, the first evaluation would be that of the tidal volume. In these various diseases, as the expiratory reserve volume increases so does the functional residual capacity which requires a greater volume of air with which to mix in order to maintain normal gas concentrations.

Thus, there is developed some of the reasoning behind the need to understand these various capacities and volumes. In actual practice with the spirometer, one measures tidal volume and all the components of the vital capacity separately and together. These are measured at normal slow rates and are also done forceably to get some idea of what is happening within the lungs. This will be developed further in Parts IV and V. By various techniques one can measure the total lung volume. In practice the functional residual capacity is measured by working with closed circuit equipment the inspiratory capacity is added to the functional residual capacity to obtain total lung volume.

Another term that is frequently spoken of is that of compliance. This is a relative term designed to represent degree of pulmonary elasticity and is evaluated as the amount of air flow into or out of the lungs per cm. of water pressure. As obstructive disease develops the A force (or chest cage) has to build up greater negative and greater positive pressures to cause the same amount of air flow. The lungs then are spoken of as losing compliance, or getting stiff, and the volume of air flow per cm. of water pressure

gets smaller. Compliance will not be discussed any further at the present time.

Next, the spirometer will be discussed referring to diagram labelled Fig. 10. The patient is connected by means of a mouth piece, usually with a CO_2 absorber in it, to an airtight drum with water seal and counterbalanced. This is so arranged that there is one volume which includes the volume of the lungs and oral nasal passages, the volume of the tubing and the volume of the spirometer itself. The spirometer is connected with chain and counter balance so that there is no resistance to moving. It writes on a moving drum the speed of which can be controlled. When the volume in the lung increases it must come from within the water-sealed bell so that this latter volume decreases and goes down. This causes the pen to write on the revolving drum in an upward direction. By this means we get a graphic representation of breathing. There are many different types of spirometers, some are waterless and have a rubber seal. They may be quite simple as the one diagrammed or they may be increased to include spirometers with carbon dioxide absorbers on the expiratory side and in which oxygen can be controlled and injected at the rate carbon dioxide is removed for continuous and long-term breathing. In a spirometer as at Section B, there will be very little change in volume since the CO_2 is not absorbed and it will write a flat and normally equal curve as at B. If a CO_2 absorber is added one can breathe for longer periods because the CO_2 content of the drum is not increased. The oxygen in the spirometer is used up as we breathe, this being the limiting factor. The carbon dioxide put back in is absorbed and oxygen is used up and we will get a rising curve as at C. When the individual is going to be breathing more than 15 to 30 seconds, it is wise to have a two-way system which absorbs CO_2, adds oxygen back at the rate used, and this way the individual can continue to breathe for an undetermined period of time. The oxygen concentration of the air is maintained and the carbon dioxide is absorbed. There are other techniques for measuring these volumes such as body platysmograph. These will not be discussed.

At this point the beginning of pulmonary function testing as it relates to the normal breathing pattern will be discussed. The normal tidal volume varies with age, body size, degree of exertion, etc. This can be determined from tables. The first change in tidal volume is usually that of volume itself due to increase in dead space (increase in non-functioning pulmonary units that must be ventilated in order to ventilate normally functioning pulmonary units). The first thing to consider in evaluating tidal volume is the volume itself in relation to what it really ought to be. Anyone, once he is put on breathing equipment, is conscious of his breathing and will breathe deeper and faster than normal. The normal tidal volume is demonstrated in Diagram 11A. Hyperventilation, or increased tidal volume, is seen at B. As chronic lung disease enters into the picture and trapping occurs and as marked loss of elasticity occurs with emphysema, then there is no real base-line or resting chest-cage position. Breathing is, as a rule at this point, active on both inspiration and expiration and the tidal volume tends to vary widely, particularly as one does the various function studies and the pattern as at C in Diagram 11 is assumed.

The next breathing pattern is that pattern in which the individual is no longer sensitive to CO_2 so that the patient now breathes primarily because of oxygen deficiency. As arterial oxygen saturations fall then there is a stimulation to slowly increase breathing that reaches a maximum and then slowly decreases. As arterial oxygen rises then there is a period of apnea until oxygen levels fall again. This is known as Cheyne-Stokes respiration as represented at D.

There is a second form of breathing that is periodic and can be seen in the tidal volume. In this form of breathing, the breathing is full and continuous with periods of apnea, and is due to disease within the midbrain.

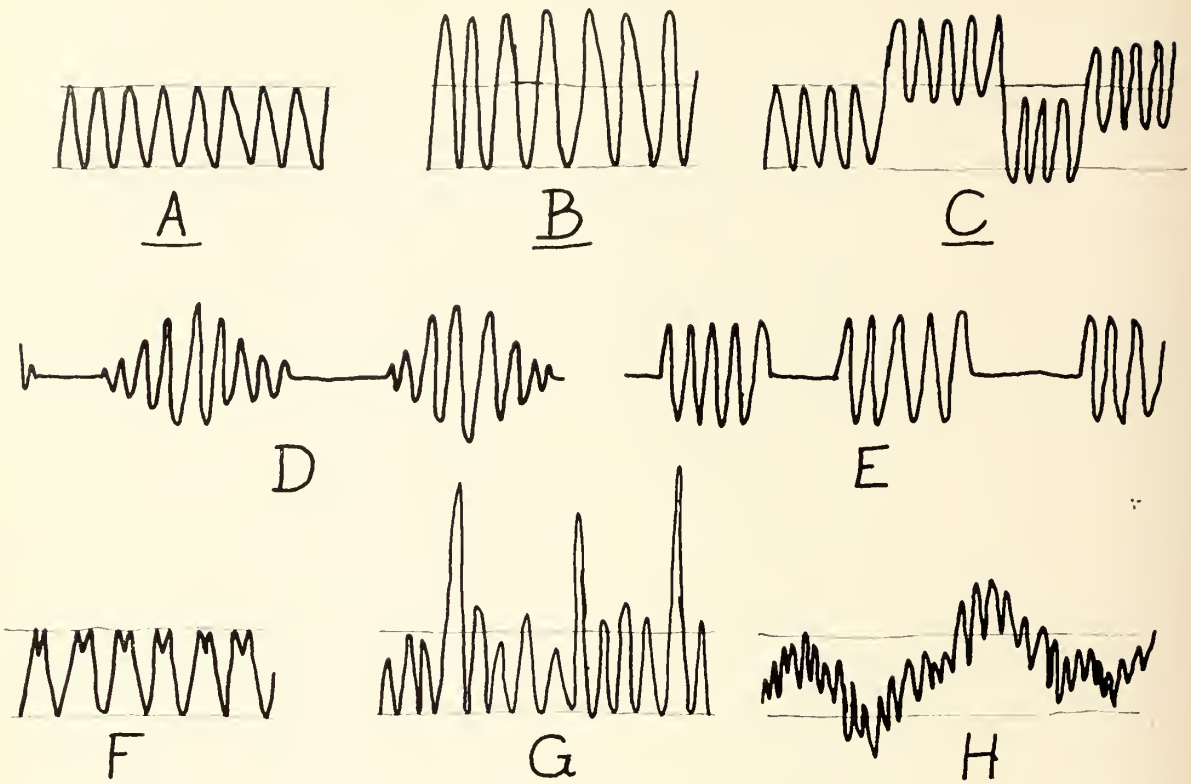


Diagram No. 11

This is known as biotts breathing. It is demonstrated in Diagram 11E.

At F, in Diagram 11, is a pattern in which each inspiration has a notch. This is an unusual pattern that has been seen in early bulbar polio before actual paralysis occurs and also occurs in tumors and abscesses in the respiratory area of the brain. The exact reason for the notches is not well understood, other than that this is probably a disparity between the end of inspiration with elastic recoil of the lungs causing some collapse and then bouncing back before expiration is accomplished as a result of poor communications between the inspiratory and expiratory centers in these conditions.

Next is that pattern that is seen with the chronic anxiety state in which there are frequent deep sighs, a variation of the depth of respiration, and this tidal volume pattern is usually diagnostic of an anxiety state and, as a rule, poor function studies are noted with this type. This is due to anxiety and poor cooperation.

At H is a pattern that is typically seen in schizophrenics, in which there usually is a degree of hypoventilation associated with the shallow, irregular breathing pattern with a wandering base line which is usually diagnostic of schizophrenic states.

In summary, the tidal volume, the pattern of the tidal volume, the volume, the variation of base line, etc., all can give a considerable amount of information about the patient even including the acute anxiety states and schizophrenia. In doing tidal volumes, it is necessary to be assured the patient is breathing at ease and fairly normally for himself with the equipment. In the anxiety patient, G, of Diagram 11, it is rarely possible to get him to cooperate with the equipment to the extent that one can get satisfactory function studies. If the equipment will allow, however, an individual should be allowed to breathe normally on the machine until he gets over the anxiety of being attached to such equipment, until he feels comfortable breathing and feels he is breathing normally.



PROTEIN CONTENT / 7 oz. Serving*

Bean with Bacon	6.8	Green Pea with Ham (Frozen)	7.6
Beef	8.0	Hot Dog Bean	8.4
Chicken Broth	5.5	Pepper Pot	6.1
Chicken 'N Dumplings	5.8	Split Pea with Ham	10.2
Chili Beef	6.2	Vegetable Beef	5.0
Green Pea	6.9	Vegetable with Beef (Frozen)	5.4

When protein is the focal point in your patients' special diets, Campbell's Soups can be a convenient supplementary source of that essential nutrient.

* From "Nutritive Composition of Campbell's Products" which gives values of important nutritive constituents of all Campbell's Products. For your copy, write to Campbell Soup Company, Dept. 365, Camden, New Jersey 08101.



There's a soup for almost every patient and diet ...for every meal and, it's made by Campbell



LOMOTIL®

TABLETS/LIQUID

Each Lomotil tablet and each 5 cc. of Lomotil liquid contain:
diphenoxylate hydrochloride .....2.5 mg.
(Warning: May be habit forming)
atropine sulfate .....0.025 mg.

One hundred per cent of all travelers who have traveled 200,000 miles or more away from home have relied on Lomotil to control diarrhea.

When your patients need a reliable antidiarrheal—at home or away from home—rely on Lomotil.

In diarrheas associated with:

- gastroenteritis
- acute infections
- functional hypermotility
- irritable bowel
- ileostomy
- drug-induced diarrhea

Warnings: Lomotil should be used with caution in patients taking barbiturates and, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Signs of accidental overdosage may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise. Respiratory depression and coma may occur with overdosage.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children:

3-6 mo.	½ tsp.* t.i.d. (3 mg.)
6-12 mo.	½ tsp. q.i.d. (4 mg.)
1-2 yr.	½ tsp. 5 times daily (5 mg.)
2-5 yr.	1 tsp. t.i.d. (6 mg.)
5-8 yr.	1 tsp. q.i.d. (8 mg.)
8-12 yr.	1 tsp. 5 times daily (10 mg.)
Adults:	2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful

Maintenance dosage may be as low as one-fourth the initial daily dosage.

G. D. SEARLE & CO.
P. O. Box 5110, Chicago, Illinois 60680
Research in the Service of Medicine 952



Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS



around the state

Vital Statistics

NEW MEMBERS

Etowah County

Grimes, Larry Dewey, b 36, mc Alabama 63, sb 64, 514 Walnut Street, Gadsden, Alabama 35901 OB-GYN.

Jefferson County

Ballard, James Wayland, b 38, mc Alabama 64, sb 65, 3801 Ansley Road, Birmingham, Alabama 35213 R. (transfer from Pickens County)

Blanton, James Henry, b 36, mc Alabama 61, sb 62, 1909 Laurel Road, Birmingham, Alabama 35216 I.

Bradford, Depew Elliott, b 24, mc Meharry 47, recip. NBME 54, 1630 4th Avenue, North, Birmingham, Alabama 35203 GP, (transfer from nonmember)

Cobbs, Charles Glenn, b 34, mc Harvard 63, recip. NBME 64, 1919 South 7th Avenue, Birmingham, Alabama 35233 I.

Flowers, Charles Ely, Jr., b 20, mc Johns Hopkins 44, recip. North Carolina 68, 1919 South 7th Avenue, Birmingham, Alabama 35233 OB-GYN.

Gay, Madison Waller, b 42, mc Alabama 68, sb 69, 1521 16th Street, South Apt. J, Birmingham, Alabama 35205 D.

Hallenbeck, George Aaron, b 15, mc Northwestern 40, recip. Minnesota 68, 1919 South 7th Avenue, Birmingham 35233 S.

Lorincz, Andrew Endre, b 26, mc Chicago 52, recip. Florida 69, 1919 South 7th Avenue, Birmingham, Alabama 35233 Pd.

Mathews, Robert David, b 40, mc Alabama 68, sb 69, 1701 25th Street, North, Birmingham, Alabama 35234 S.

Mills, Patrick Leonard, b 36, mc Alabama 62, sb 63, 1000 South 14th Street, Birmingham, Alabama 35205 U, (transfer from nonmember Marengo County)

Peacock, Thomas Hansel, Jr., b 37, mc Alabama 63, sb 64, 1516 Stratosphere Lane, Alexandria, Louisiana 71301.

Poole, William Lannan, Jr., b 39, mc Alabama 64, sb 65, 2748 Abingdon Road, Birmingham, Alabama 35243 D.

Riederer, Robert Edward, b 16, mc Kansas 42, recip. Kansas 69, 1500 6th Avenue, South, Birmingham, Alabama 35233 I.

Sampson, Larry Wayne, b 39, mc Bowman Gray 63, recip. North Carolina 69, 8436 1st Avenue, North, Birmingham, Alabama 35206 D.

Lauderdale County

Pritchard, Charles David, b 37, mc University of Tennessee 62, recip. Tenessee 69, 883 Florence Boulevard, Florence, Alabama 35630 S.

Madison County

Snapp, Jack Tipton, b 28, mc University of Tennessee 60, recip. Mississippi 69, 410 Lowell Drive, S. E., Huntsville, Alabama 35801 U.

Montgomery County

Engelhardt, Miller Bonner, b 38, mc Alabama 64, recip. Louisiana 69, 2119 East South Boulevard, Montgomery, Alabama 36111 OR.

MEMBERS DECEASED

Barbour County

Adams, John Ball, Eufaula, Alabama, deceased September 24, 1969.

Dale County

Smith, Gordon Roysce, 255 West Reynolds Street, Ozark, Alabama, deceased November 2, 1969.

MEMBERS REMOVED

Franklin County

House, Roy Franklin, Jr., moved to Rochester, Minnesota.

CHANGES OF ADDRESS

Calhoun County

Stallworth, Nicholas Robert, present Jacksonville, to P. O. Box 229, Jacksonville, Alabama 36265.

Choctaw County

Gully, Virgil Samuel, present Tuscaloosa, to 410 Zara Street, Butler, Alabama 36904.

Cullman County

Whiteside, Maurice Scarbrough, present Tucson, Arizona, to 100 Sixth Avenue, S. E., Cullman, Alabama 35055.

Dallas County

Chapman, Jesse P., present Selma, to 81 Sheridan Road, Asheville, North Carolina 28803.

Jefferson County

Botta, Louis Patrick, present Birmingham, to United Security Life Building, Birmingham, Alabama 35218.

Brice, Donald Wyman, present Birmingham, to 1604 Choctaw, Dothan, Alabama 36301.

Caceres, Jorge Alberto, present Fairfield, to 1622 7th Avenue, North, Bessemer, Alabama 35020.

Doss, Faye Williams, present Birmingham, to 736 Tuscaloosa Avenue, Birmingham, Alabama 35211.

Edwards, W. Sterling, III, present Birmingham, to 717 Wagontrain Drive, S. E., Albuquerque, New Mexico 87112.

Hazelrig, Cooper Green, present Birmingham, to 1320 South 19th Street, Birmingham, Alabama 35205.

Litzinger, Morgan John, Jr., present Birmingham, to 3036 Brook Hollow Lane, Birmingham, Alabama 35234.

Mathis, James William, present Valdosta, Georgia, to 209 Pendleton Drive, Valdosta, Georgia 31601.

McLarey, Don Curtis, present Birmingham, to 2425 South 68th, Galveston, Texas 77550.

Mitchell, Sidney Ashley, present Birmingham, to P. O. Box 346, Fultondale, Alabama 35068.

Moody, William Edwin, present Moulton, to 5350 1st Avenue, North, Birmingham, Alabama 35212.

Reid, Joel Wesley, present Birmingham, to P. O. Box 2603, Birmingham, Alabama 35201.

Riheldaffer, William Howard, present Birmingham, to 1328 Willoughby Drive, Birmingham, Alabama 35216.

Scott, Edward Van Zile, present Birmingham, to 1000 14th Street, South, Birmingham, Alabama 35205.

Sussex, James Neil, present Birmingham, to 1000 Northwest 17th, Miami, Florida 33136.

Wilson, Ollie E., present Birmingham, to 1621 28th Street, West, Fairview Station, Birmingham, Alabama 35218.

Zenger, George H., present Birmingham, to 4201 Kennesaw Drive, Birmingham, Alabama 35213.

Lauderdale County

Herring, John S., present Florence to 120 South Locust Street, Florence, Alabama 35630.

Melson, Gilbert R., present Florence, to 102 South Pine Street, Florence, Alabama 35630.

Mobile County

Cope, William F., Jr., present Mobile, to 1720 Springhill Avenue, Suite 105, Mobile, Alabama 36604.

Miller, Joseph B., present Mobile, to Suite 110, Three Office Park, 3931 Airport Boulevard, Mobile, Alabama 36609.

Murdock, Church E., Jr., present Mobile, to 1707 Springhill Avenue, Mobile, Alabama 36604.

Montgomery County

Bennett, Willard D., present Montgomery, to 750 Washington Avenue, Montgomery, Alabama 36104.

Hughes, William D., present Montgomery, to 750 Washington Avenue, Montgomery, Alabama 36104.

May, William P., present Matthews, to 750 Washington Avenue, Montgomery, Alabama 36104.

Morgan County

McCain, Paul P., present Decatur, to P. O. Box 1383, Decatur, Alabama 35601.

Nash, James C., Jr., present Decatur, to 429 Jackson Street, S. E., Decatur, Alabama 35601.

Tuscaloosa County

Partlow, Rufus C., Jr., present Tuscaloosa to Zero Emerson Place, Charles River Park, Boston, Massachusetts 02114.

CHANGES OF SPECIALTIES

Lauderdale County

Herring, John S., 120 South Locust Street, Florence, Alabama 35630, Obstetrics, Gynecology.

MEMBERS TRANSFERRED

Montgomery County

Brock, William M., 520 Dalraida Street, Montgomery, Alabama, from member Lee County Medical Society to member Montgomery County.

Langley, John O., 1720 Center Street, Mobile, Alabama, from member Jefferson County Medical Society to member Mobile County Medical Society.

NEW TELEPHONE NUMBERS

Ballard, James W., Jefferson	967-1689
Blanton, James Henry, Jefferson	823-1033
Bradford, Depew E., Jefferson	254-3773
Caceres, Jorge A., Jefferson	428-6271
Carrington, Sewart G., Mobile	433-1661
Cobbs, Charles Glenn, Jefferson	934-5191
Doss, Faye W., Jefferson	785-3145
Flowers, Charles Ely, Jr.,	934-4757
Gay, Madison Waller, Jefferson	934-4141
Hallenbeck, George Aaron, Jefferson	934-5388
Hazelrig, Cooper G., Jefferson	328-8713
Herring, John S., Lauderdale	764-5532
Langley, John Olin, Mobile	433-1506
Litzinger, Morgan, Jr., Jefferson	967-2299
Lorincz, Andrew Endre, Jefferson	934-5467
Mathews, Robert David, Jefferson	328-6298
McRae, James D., Montgomery	288-1405
Miller, Joseph B., Mobile	342-8540
Mills, Patrick L., Jefferson	328-0845
Murdock, Church E., Jr., Mobile	433-8463
Peacock, Thomas Hansel, Jr., Jefferson	448-5639
Poole, William Lannan, Jr., Jefferson	967-3516
Poteet, James E., Montgomery	288-1405
Pritchard, Charles D., Lauderdale	766-2702
Riederer, Robert Edward, Jefferson	252-9931
Sampson, Larry Wayne, Jefferson	836-6292
Schnaper, Harold W., Jefferson	934-3350
Scott, Edward Van Zile, Jefferson	328-0845
Wingard, Christian, Jr., Mobile	432-1631
Zickler, James B., Lauderdale	766-5091

Antigens—And Life Or Death

Studies of the body's reactions to antigens in the streptococci which cause certain diseases and which evoke a reaction that is a prominent component in transplant rejection will be conducted by scientists at the New York University Medical Center under a grant of $248,428 from The John A. Hartford Foundation, Inc.

The principal investigator will be Dr. Felix T. Rapaport, associate professor of surgery at the NYU School of Medicine. The laboratory studies will be conducted in the Medical Center's Institute of Reconstructive Plastic Surgery, where Dr. Rapaport is director of research.

The body's protective mechanism against invasion by foreign matter is stimulated even when organs are transplanted for the purpose of saving a patient's life. The transplanted material contains antigens which evoke a response from the host's cells, eventually rejecting the foreign or "non-self" organ. The body normally will not react to its own antigens.

However, recent studies have indicated that the host only tolerates those of its own antigens located at the cell surface. The sudden release of antigens within cells following trauma and/or infection, such as that caused when a cell is injured by a streptococcus, might activate a response resulting in organ destruction.

Spokane Radiologist Becomes A Priest

A Spokane radiologist who feels his call to the ministry and to medicine are "from God" has been ordained as an Episcopal priest. "I just had to do it," explains E. Finch Parsons—an appropriate name for a minister!

Because he believes medicine and religion go hand in hand, Dr. Parsons has been spending his evenings and weekends pursuing his studies for the Episcopal priesthood.

Five years ago, Dr. Parsons was ordained a deacon and since then he's been assisting at St. John's Episcopal Cathedral and practicing radiation therapy at the Rockwood Clinic. As a priest he will be able to celebrate Holy Communion, hear confessions, pronounce absolution and solemnize marriages.

Dr. Parsons, a graduate of Yale University and the Columbia University Medical School, is married and the father of two sons and a daughter.

—ACR Bulletin

A Baby's Future

Johnny is slightly deaf. His mother thinks he's "mentally slow" because he doesn't respond whe she speaks to him. When she wants something done, she asks one of her other children to do it. Johnny is essentially ignored.

Because no one has realized Johnny is partially deaf, he is missing a great deal of valuable information and experience.

At the present time, there is no good diagnostic test for picking out the problems in babies that possibly cause later inadequacies, according to an Emory University psychologist. Dr. Herbert Kaye, associate professor of psychology and gynecology-obstetrics, is devoting a major portion of his research effort toward developing diagnostic tests to do just that.

In specially designed booths at Grady Memorial Hospital in Atlanta, thousands of newborn babies are tested for tactile and auditory sensitivity and conditioned associations and preferences. Eventually, a battery of tests will be constructed to examine the learning, sensory, and memory characteristics of newborns.



Owner Breaks Arm When Yacht Runs Agroun

Schuyler, Oct. 31. Harry Waters of Covesville incurred a fractured arm [illegible] large rock tially capsized. The fire depa had to rescue Waters by smal Damage to the yacht is estim

Hasn't the skipper had enough excitement for one day?

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

A.H. Robins Company, Richmond, Va. 23220 A·H·ROBINS

Phenaphen® with Codeine

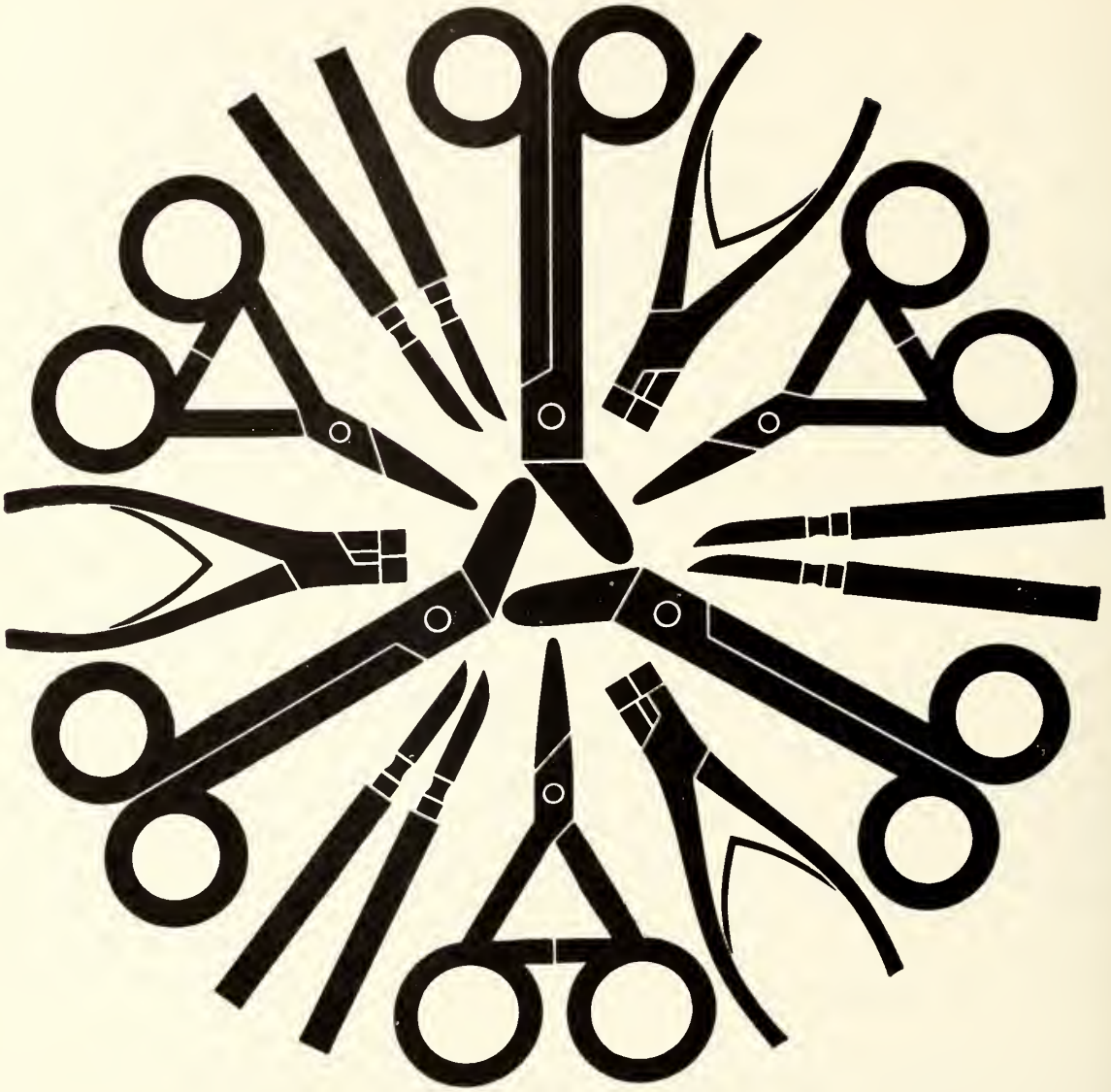
Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. Contraindications: Hypersensitivity to any of the components. Precautions: As with all phenacetin-containing products excessive or prolonged use should be avoided. Side effects: Side effects are uncommon, although nausea, constipation and drowsiness may occur. Dosage: Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.



before and after surgery



Berocca®

TABLETS
high potency B-complex and C
for nutritional support

AVAILABLE ONLY ON Rx

contains water-soluble vitamins only

b.i.d. dosage

good patient acceptance

no odor, and virtually no aftertaste

Each Berocca Tablet contains:

Thiamine mononitrate	15 mg
Riboflavin	15 mg
Pyridoxine HCl	5 mg
Niacinamide	100 mg
Calcium pantothenate	20 mg
Cyanocobalamin	5 mcg
Folic acid	0.5 mg
Ascorbic acid	500 mg

Usual dosage is one tablet b.i.d.

Indications: Nutritional supplementation in conditions in which water-soluble vitamins are required prophylactically or therapeutically.

Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B_{12}.

Dosage: 1 or 2 tablets daily, as indicated by clinical need.

Available: In bottles of 100.

ROCHE

Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Hobbies To Fill A Doctor's Leisure

The Most Intriguing of These is Politics

Doctors who make good in medicine are legion—a dedicated group restrained by a self-imposed code of ethics that other professions might envy. Even the clergyman may look to the physician for inspiration.

But those who work hard must also play hard if they would live past the prime of the middle years.

The ways doctors play are legion also, comparable to the hobbies of any other profession or vocation—with a single notable exception. Even today, when politics is recognized by most doctors as a way of survival, they enter into it reluctantly.

However, there are a hardy few who plunged into the sea of politics just for the fun of it. Some of those few are the subject of this month's entry in the doctor's-hobby series. And almost any one of them would deny the allegation of the first sentence of this paragraph—that his interest was primarily for the fun of it.

First, there is Dr. Robert Parker, Montgomery pediatrician, whose interest in the political game matured early under the unaware tutelage of one of the most astute politicians in 20th-century Alabama, William Adams Gunter, known to the day of his death as "the perpetual Mayor of Montgomery." Bob Parker and the Mayor's son, destined also for the study of medicine, were inseparable friends from childhood.



Dr. R. Parker

Spending so much time in the Gunter home on South Perry, this friend of William A. Gunter, III was exposed continually to the way of practical politics. Ask him what are his hobbies and he is apt to reply: turkey and quail hunting, fishing and dove shooting. Politics, if mentioned at all, is an afterthought. But don't be fooled by this modesty. He is as proud of his involvement in the machinations of democratic government as of his dexterity, patience, and marksmanship in pursuit of an elusive tom-turkey.

John Murphy Chenault, M. D., who was born only weeks after the heir-apparent to the Austro-Hungarian throne died to set a world afire, may be said to have entered the field of politics obliquely, from the distaff side. Diplomacy is one of the few synonyms for politics listed by Roget, and tact is a characteristic that one automatically associates with this Chairman of the Board of Censors of the Medical Association of the State of Alabama.



Dr. J. Chenault

When Mrs. Chenault, the former Belle Montgomery of Tuscaloosa, first became involved actively in work of the Woman's Auxiliary of the Medical Association, her doctor-husband discovered the fascination of politics in that loosely knit group of organizations. Mrs. Chenault, who currently occupies the highest office within the gift of the distaff side of medicine as president of the Woman's Auxiliary of the American Medical Association, is a past president of

both WAMASA and of the Woman's Auxiliary of the Southern Medical Association.

Today, only the politically naive would overlook the name of John M. Chenault, M. D., wherever medicine is pushed into the political arena. The Board of Censors, over which Dr. Chenault presides as chairman, actually wears at least two other hats. It is the Board of Health and also the Board of Medical Examiners. With these interests it is necessary to maintain continuous liaison with state and national government, including the Legislature and the Congress.

"And when we approach any of them—the President or the Congress, the Governor or the Legislature—they realize that the doctors of Alabama seek only the public's welfare in the area of health care," Dr. Chenault said.

Dr. Chenault's most recent honor was election to AMA's Board of Trustees.

James Johnston Hicks, M. D., Birmingham ear, nose and throat specialist, and brother of the 6th Congressional District's ALAPAC Board member, represents a third distinct type of political involvement. He was very much surprised that his practical interest in practical politics had become known outside the tight little circle in which his ballot ideas became accomplished facts.



Dr. J. J. Hicks

To anyone interested generally in the hobby that interests this Dr. Hicks, when he is not treating or operating on the diseases of his specialty, he would direct them to Brier Hill, over in Bullock County, where a prize-winning herd of Angus cattle roams the rolling pastureland. Perhaps there is subtle significance in the fact that Brier Hill is neither a plantation nor a ranch, though it could qualify as either by Webster's interpretation of the words. It is simply Brier Hill Farm.

The frayed cliche, "still water runs deep," is as applicable to this Dr. Hicks as to any M. D. in Alabama. But of his unheralded, unheadlined influence in the field of politics, one might talk confidentially with almost any highly successful and knowledgeable politician, at the national level, the state level, or in the imperial county of Jefferson. They know!

Asked for his formula of success in this area, Dr. Hicks responded promptly: "I've always told them the truth, and they tell me the truth."

And finally there's the old challenge to "put your money where your mouth is," which in more polite English means simply: "You talk well enough, but are you as ready to act?"

Let two physicians who have run for political office in Alabama be the concluding subjects of this piece on doctors who have politics for a hobby. One was an unsuccessful candidate for Governor of his home state, the other a repeatedly successful candidate for Mayor of his hometown.

First there is Carl Ray Robinson, who is two kinds of doctor—an M. D. and a J. D. (Jurum Doctor)—qualified to practice law as well as medicine. There is perhaps a deep significance in the fact that Dr. Robinson, who is listed in the Roster of the Medical Association of the State of Alabama, as in General Practice at a Bessemer address, sent his requested Curriculum Vitae into MASA in



Dr. C. Robinson

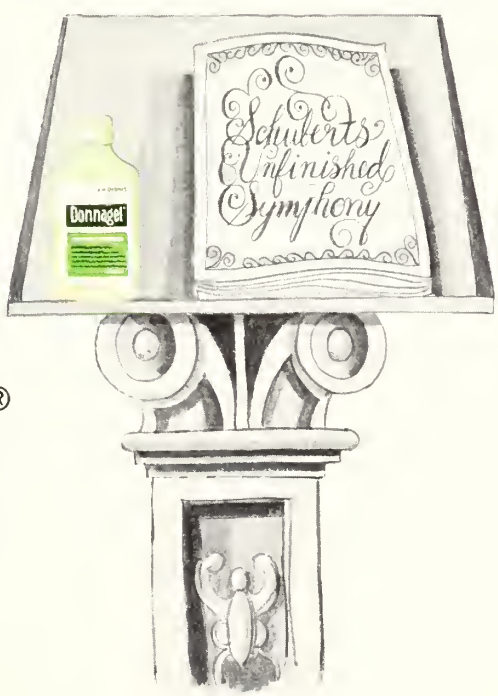
(Continued on Page 776)



The concert was just underway,
When to the conductor's dismay
Cramps and diarrhea,
Did so quickly appear,
The maestro no longer could stay.

Because diarrhea with cramping, nausea, and painful straining can t the most inopportune time, it takes a comprehensive agent to treat the arrheal syndrome and help get the patient back on the job. That's why y physicians rely on Donnagel, especially during the fall and winter when "flu" and viral gastroenteritis usually hit their peak.

Donnagel is much more than just a simple kaolin-pectin combination. contains the belladonna alkaloids to calm GI hypermotility and help the distressing discomforts which so often accompany diarrhea. Certainly expensive and more convenient than taking two medications. And the is lower too. Available in the handy 4-oz. plastic bottle at pharmacies ere on your prescription or recommendation.



rrhea and its Discomforts

Donnagel®

id ounce contains: Kaolin, 6 Gm.; Pectin, 142.8 mg.; Hyoscyamine sulfate, mg.; Atropine sulfate, 0.0194 mg.; Hyoscine hydrobromide, 0.0065 mg.; benzoate (preservative), 60 mg.; Alcohol, 3.8%.

ROBINS A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220


PHOTO BY VICTOR HA


A H ROBINS
Robitussin
Robitussin-DM
Robitussin A-C
Robitussin-PE
4 FL OZ.
Robitussin-DM
Cough Calmers

CLEAR THE TRACT!

THERE'S A ROBITUSSIN FOR EVERY COUGHING NEED

All the Robitussins contain gylceryl guaiacolate, an outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Alcohol, 3.5%

Non-narcotic for 6-8 hr. cough control
ROBITUSSIN-DM®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Dextromethorphan hydrobromide . . . . 15.0 mg.
Alcohol, 1.4%

For unproductive allergic coughs
ROBITUSSIN A-C®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Pheniramine maleate . . 7.5 mg.
Codeine phosphate . . . 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN-PE®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Phenylephrine hydrochloride. . . . . 10.0 mg.
Alcohol, 1.4%

Robitussin-DM in solid form for "coughs on the go"
COUGH CALMERS™
Each Cough Calmer contains:
Glyceryl guaiacolate . . 50.0 mg.
Dextromethorphan hydrobromide . . . . 7.5 mg.

Use this handy guide to pick the right formulation for each coughing need

	Robitussin	Robitussin-DM	Robitussin A-C	Robitussin-PE	Cough Calmers
Expectorant	●	●	●	●	●
Demulcent	●	●	●	●	●
Cough Suppressant		●	●		●
Antihistamine			●		
Long-Acting (6-8 hours)		●			●
Nasal, Sinus Decongestant				●	
Non-narcotic	●	●		●	●

A·H·ROBINS A. H. Robins Company, Richmond, Va. 23220

(Continued from Page 772)

an envelope bearing the legend: Carl Ray Robinson, Attorney at Law.

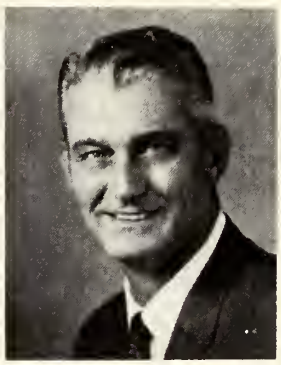
Born in Graysville, Alabama, graduating at 17 as Valedictorian and Class President of his Ensley high school, he promptly entered the army in the summer of 1943, returning three years later from the Marianas Islands for discharge from the Army Air Corps with a severe knee injury.

He received his A. B. from Birmingham-Southern, his M. D. from Alabama (1948), his J. D. from Samford in January, 1965; practicing medicine since 1953, and law since 1965. Married, he and his wife, Esther, have five children. Despite the fact that he spent the last two weeks of the campaign in the hospital with a fractured lumbar vertebra, Dr. Robinson received some 50,000 votes in his race as an independent for Governor of Alabama in 1966. And it was doubtless in answer to a direct question of the author of this article, that he noted at the bottom of his C. V.:

"Did not enter politics as a hobby but with a genuine interest to try to help Alabama get on the road to progress and . . . in my platform . . . you will find that it contained programs offering solutions to the major problems the Legislature has had to face since that time, such as medicaid, improved education and teacher salaries, the usury laws, air and water pollution problems, and many others essential to a healthy and strong Alabama."

And finally, in this array of doctors involved in politics, there is James L. Hardwick, M. D., who is listed in the MASA roster as a General Practitioner, but who appears on stationery of the City of Talladega as: J. L. Hardwick, Mayor, Commissioner Public Safety and Public Health.

Born in Slocomb, Geneva County, December 30, 1918, he received his M. D. degree from Tulane in 1943, and a decade later was elected to his first term as Mayor of Talladega, where he had been in General Practice for nine years. He is married to the former Dorothy Pierce.



Dr. J. Hardwick

The nervous breakdown of one of two candidates for Mayor actually launched Dr. Hardwick on a political career. A former Mayor and the incumbent representing differing political philosophies, were to face one another in the city primary. When the latter collapsed and the former seemed certain to win by default, the friends of Dr. Hardwick drafted him. He beat the qualification deadline by hours. He will not offer for reelection in 1971, "because the Mayor's responsibilities have become a full-time job."

Dr. Hardwick confesses to a hobby that is closely related to politics:—"public speaking, to clubs, banquets, dedications, etc., on subjects relating to politics, medicine, or Red-White-and-Blue occasions."

A sixth doctor was to have been included in this politics-for-a-hobby feature. But this Mobile General Practitioner admits that he has turned from vote-hunting to the hunt for old bottles because it's "less frustrating." He and a Psychiatrist from Tuscaloosa will be the subjects of a feature on his new hobby in the March issue of The Journal of the Medical Association of the State of Alabama.



The Bradley Center --- for the problems of living

An all new homelike open psychiatric residence on a lovely five-acre tract, centrally located within the community, providing a comprehensive range of continuous services, including in-patient, day care, and outpatient treatment. Each patient participates in an extensive and intensive treatment program, based almost exclusively upon multiple psychotherapeutic encounters. These include individual psychotherapy, group psychotherapy, the nursing milieu, occupational therapy, recreational therapy, topical small group discussions, and other group activities in the Center, as well as in the community, depending on individual needs and interests. Medications are prescribed when appropriate.

Any individual may be admitted who, in the opinion of the medical staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible family member.

Accredited by the Joint Commission on Accreditation of Hospitals.

Leonard T. Maholick, M. D.
Medical Director

Maj. Gen. (ret.) Howard Snyder
Administrator

THE BRADLEY CENTER, INC.
2000 Sixteenth Avenue
Columbus, Georgia 31901
Area Code 404 324-4882



Blue Shield's new URC program recognizes your "out-of-the-ordinary" charges through individual consideration by review committees composed of physicians.

BLUE CROSS-BLUE SHIELD OF ALABAMA

®

Mobile Doctor Among Ten 50-Year Club Additions For 1970

James Leslie Taylor, M. D., Mobile, is one of ten Alabama doctors qualifying for this year's Medical Association 50-Year Club, to be awarded a Certificate of Distinction and to be inducted into the Club at the annual meeting in Mobile.



Dr. Taylor

Service in World War I interrupted his medical education, but he was graduated from Tulane University in 1920 with an M. D. degree. He saw service also in World War II, currently retired from the A. U. S. Medical Corps with the rank of colonel.

A specialist in general and industrial surgery, Dr. Taylor is on the staffs of the Mobile General Hospital, Mobile Infirmary, Providence Hospital, and Doctors Hospital. A Fellow of the American College of Surgeons, the American Society of Abdominal Surgeons, and the Industrial Medical Association, he is a member of the American Society of Railroad Surgeons, of AMA, of MASA, and of the Mobile County Medical Society.

Dr. Taylor is married to the former Mary Gourley. He has one daughter, Mrs. Arthur B. Pope (the former Mary Taylor), and three grandchildren. He lists his hobbies as fishing, hunting and camellia culture.

A Mobile Flying Doctor

While flame and bursting steel still rained from the skies on the other side of the Atlantic and the other side of the Pacific, in what is known as World War II, a Birmingham teenager was learning to fly. Today this Mobile neurosurgeon pilots his own plane, an active member of the Flying Physicians' Association as well as the Medical Association.

Robert Hiden Mudd, who received his M. D. degree from the University of Pennsylvania in 1951, is married to the former Emelil Davis, also a Birmingham native, and they have two children—Robert H. Mudd, Jr., 14, and Margo, 11. The four of them frequently fly together, sometimes even out of the country. A year ago December 28th they flew to the Bahamas in Dr. Mudd's Cessna 182.

As readers of the Journal learned in the issue of two months ago, Dr. Mudd has another absorbing hobby in fishing for the big ones, and his plane serves frequently to taking him in a hurry to such favorite angling areas as the Chandelier Islands off the Mississippi coast.



Dr. and Mrs. Mudd

Fathers and Sons in Medicine

Germany At War Altered Starting Careers Of Both McVays

Leon Victor McVay, the first and second of that name, are a father-and-son team practicing medicine together in Mobile.

They earned their M. D. degrees 30 years apart (in 1915 and 1945) and our wars with Germany directly affected the start of the careers of both—one interrupting his internship at St. Margaret's in Montgomery to enlist in the service of his country, the other as this nation's last exchange student to Heidelberg having his student days there terminated by World War II.

The senior Dr. McVay was born in history-rich Clarke County, in the Indian-named town of Salitpa, on Tuesday, November 25, 1890. He attended Greensboro's Southern University, forerunner of Birmingham-Southern, before entering the University of Alabama's School of Medicine in Mobile, from where he received his M. D. degree in June, 1915. He was welcomed into the exclusive ranks of MASA's 50-Year Club five years ago.

Leon Victor, Jr., the McVays' only child, was born in Atlanta, where his father was stationed on military duty, three months after the end of World War I, on Sunday, February 9, 1919. Ordered home from Heidelberg as roaring guns heralded the opening of World War II, the junior McVay transferred to Harvard, from which he received his baccalaureate.

Subsequently, he earned his M. D. and M. S. (in pathology) degrees from the University of Tennessee College of Medicine, serving a rotating internship at Mobile General Hospital. Following his tour of service in the Army Medical Corps, he served a four-year residency in Medicine at the University of Tennessee College of Medicine, and remained there in the successive positions of Instructor, Assistant Professor and Associate Professor of Medicine.



The Doctors McVay

Recalled to active duty with the U. S. Air Force in 1953, Dr. Leon V. McVay, Jr., served for a year as Chief of Medicine at Maxwell Air Force Base Hospital. He has practiced Internal Medicine in Mobile since 1954.

Father and son are Rotarians, both are members of the Mobile Chamber of Commerce, and both are officers in the Dauphin Way United Methodist Church (the father a lifetime trustee, the son a member of the official board). The Roster of the Medical Association of the State of Alabama lists them at the the same Government Street address, the senior McVay in General Practice, his son an Internist.

The Doctors Daniel—An Alabama Trio

An absorbing interest in the medical and psychological problems of adolescence has lured a prominent Alabama pediatrician from the active practice of medicine into the cloistered halls of the teaching profession, but he has two sons ready and eager to take his place.

Once they chose to follow their father into medicine, however, each elected an entirely separate path to follow.

William Andrew Daniel, Jr., born in Thomaston, Ga., a few decades back, went to Northwestern University, Chicago, for his medical education. He interned at Charity Hospital, New Orleans, and then took pediatric training in Dallas and Chicago. He spent 20 years practicing his profession in Alabama's Capital City, in the latter years of which he watched with interest and concern the physical and psychological quirks of his growing-up patients.

When the Department of Pediatrics at the University of Alabama Medical Center decided to establish an Adolescent Unit (outpatient and inpatient facilities), it invited Dr. Daniel to direct it. He recognized the fact that while the unit is concerned primarily with the the medical problems of adolescents, it could not ignore psychological changes as factors affecting the teenagers.

Meantime his two sons, Andy and Kim (more formally, William Andrew Daniel, III and Rollin Kimball Daniel), determined early to follow their father into medicine—but no further! Both graduated from Lanier High School, Montgomery.

Andy, the eldest, went to Duke and then to Tulane Medical School. He interned at Alabama and completed his first year of surgery residency there. He is now in the Air Force, stationed at Randolph Field, Texas. Married to the former Tekla Anne York of San Antonio, they have a daughter, Anne, 1 year old, and incidentally the senior Daniels' only grandchild. Andy plans to become a Urologist with perhaps special training in pediatric urology.



Kim, Bill and Andy (in that order)

Kim went from Lanier to Vanderbilt, and then to the College of Physicians and Surgeons at Columbia, New York City, for his medical education. Presently he is interning at Barnes Hospital, St. Louis, and next year will be a surgery resident at the Royal Victoria Hospital in Montreal. He plans to become a plastic surgeon and is especially interested in hand surgery. He is married to the former Kathleen Farrell, who is working on her Master's degree, teaching deaf or brain-damaged children.

The father of the two doctor sons is married to another native Georgian, the former Jean Kimball of Winder, Georgia, and during their years in Montgomery she served a term as president of the Montgomery Junior League and was on the Montgomery Library Board during a particularly trying time in the history of Alabama.

Federal Bureau Of Narcotics Lists 15 Don'ts For Doctors

The Federal Bureau of Narcotics has prepared *Don'ts for the Practitioner* to protect him from narcotic addicts and abusers.

Don't leave presciption pads around; addicts may be forgers.

Don't write a narcotic prescription in lead pencil, or any Rx at all in pencil as they may be changed to call for morphine.

Don't write narcotics as "Morphine HT ½ ♯ X" or "Morphine HT ¼ ♯ 10." Several X's or zeros can be added to raise the amount. Use brackets or spelling.

Don't carry a large stock of narcotics in your bag. Addicts are often watching MDs' offices and cars.

Don't store your office narcotic supply unprotected, especially near a sink or washroom; patients may ask to use these facilities.

Don't fall for a story from a stranger claiming an ailment that usually requires morphine. The addict can produce blood sputum, simulate bad coughs or other symptoms. Make your own diagnosis.

Don't give an Rx to anyone except the actual patient. Addicts have posed as nurses.

Don't write for large quantities of narcotics unless unavoidable. Diversion to addicts is profitable, as much as $1 for ¼ grain M.S.

Don't prescribe narcotics on the story that another physician has been doing so; consult that physician or hospital records.

Don't leave Rx's signed in blank for nurses to fill in; many have been stolen by addicts.

Don't treat an ambulatory addict. They must be under proper control; many go to several physicians at one time.

Don't dispense narcotics without keeping records, although bedside and office administration is permissible.

Don't buy your office narcotic needs on an Rx blank. The law requires that you use an official order form.

Don't resent a pharmacist's call for verification of an Rx. He is held responsible if forgeries are filled.

Don't hesitate to call an agent of the Federal Bureau of Narcotics (at your nearest Federal Building) or the Narcotics Division of your State Department of Health if the patient is suspect. Your information will be held in strict confidence.

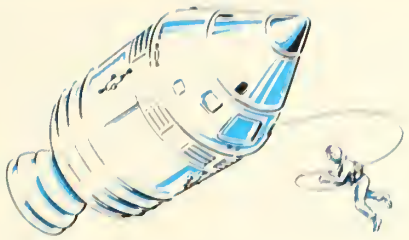
Do not phone in a *Class A Narcotic* Rx except in true emergencies; even then, the pharmacist must have a written prescription in his or his agent's hand before he can make delivery to your patient. The pharmacist or his agent may pick up the Rx at your office or at the home before making delivery.

Violations of this section of the narcotic law may entail two to 10 years imprisonment and up to a $20,000 fine for the first offense; second and third violations are more severe.

Joys Of Becoming A Doctor

According to Yngre Laeger (Denmark) the joys of becoming a doctor include that of writing one's first prescription for aspirin, of being addressed as "Doctor" on the pharmaceutical advertising, of being given the job of writing up case notes while the others go home, of having a wife who can stay home and tell the children what their father looks like in case they meet him one day, of being a junior doctor for many, many years, and of telling younger doctors how nice it is to be a doctor.

—World Medical Journal



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals

The AMBAR® SCRAPBOOK of Obesity Oddities
FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS

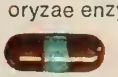
for the vitamin deficiency that diet alone doesn't satisfy...



Thera-Combex H-P® Kapseals®

is high-potency vitamin C and B-complex mbination starts where diet stops

Each Kapseal contains: ascorbic acid, 500 mg.; thiamine mononitrate, 25 mg.; riboflavin, 15 mg.; pyridoxine hydrochloride, 10 mg.; cyanocobalamin, 5 mcg.; niacinamide, 100 mg.; *dl*-panthenol, 20 mg.; Taka-Diastase® (Aspergillus oryzae enzymes), 2½ gr.



The Brown capsule with Green band is a Parke-Davis trademark.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

335R68



soothing relief for hair-raising cough

Benylin®
EXPECTORANT

Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride), Parke-Davis; 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.
An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT *is the leading cough preparation of its kind.* BENYLIN EXPECTORANT *tends to inhibit cough reflex ...soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes* BENYLIN EXPECTORANT *easy to take.*
PRECAUTIONS: *Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with* BENYLIN EXPECTORANT *should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing* BENYLIN EXPECTORANT.
ADVERSE REACTIONS: *Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.*
PACKAGING: *Bottles of 4 oz., 16 oz., and 1 gal.*
Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

50669

Now available to members of

THE MEDICAL ASSOCIATION STATE OF ALABAMA

and their immediate families

MAJORCA: THE PEARL OF THE MEDITERRANEAN

majorcan carnival



Enjoy eight days of Spanish festivity and secluded peace on Majorca. Hidden away from the hustle and bustle of the Mediterranean travel trade, you will delight in the romantic rhythms of guitars, hear the click of flamenco heels, and relax by her sunbathed cobalt seas.

DISCOVER THE UNSPOILED BEAUTY OF MAJORCA

$349 complete per person
double occupancy
plus 19.50 tax and services
via Overseas National Airways
(a certificated supplemental carrier)

Everything's Yours!

- Round trip jet flights with first class food and beverages served aloft
- DELUXE ocean-front accommodations at the Melia Mallorca Victoria Fenix or other deluxe hotel
- All transfers
- Hotel gratuities and services
- Cocktail parties and surprise fun evenings
- Sightseeing tour of PALMA the spicy Spanish city with shopping bargains galore
- Hospitality desk at your hotel with our experienced Carnival staff at your service
- Optional side trips at low prices
- Carnival tour escort throughout
- NO REGIMENTATION — You are free to do as you please when you please

PLUS! Elegant Dining

- Full American breakfasts daily at your hotel
- Gourmet dinners nightly
- Gala farewell banquet

DEPARTURE DATE: JUNE 13, 1970/DEPARTURE POINT: BIRMINGHAM, ALABAMA

THE MEDICAL ASSOC. STATE OF ALABAMA/19 So. Jackson St./Montgomery, Ala. 36104
(205)263-6441
Gentlemen

Enclosed please find $_____ ☐ as deposit ☐ as payment in full for _____ (No. of people). Make check or money order payable to: MAJORCAN CARNIVAL

$100 minimum deposit per person. Final payment due 30 days before departure.

NAME _____ PHONE _____

STREET _____

CITY _____ STATE _____ ZIP _____

DEPARTURE DATE _____ DEPARTURE CITY _____

Return this reservation immediately to insure space. Reservations limited. Rates based on double occupancy. Single rates $50 additional.

☐ Please send me your Majorcan Carnival brochure.

© Copyright 1969, AITS, Inc.

PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. MASA members having knowledge of practice opportunities or wishing to relocate their own practices are urged to communicate with the Placement Service. For further information: write Mr. Emmett Wyatt, Executive Assistant, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama 36104, or Telephone 263-6441.

Locations Wanted

General Practice—

Age 33, Medical College of Georgia 1968, seeking parttime employment on weekends and holidays relieving a general practitioner or emergency room duties in south Alabama within reasonable commuting distance of Pensacola, Fla. LW-1

Age 38; University of Oklahoma, 1955; seeking associate, institutional or industrial practice; in town of 10,000 plus population; interest in surgery. LW-5

Age 28; University of Tennessee, 1965. LW-7

Age 27, Medical College of South Carolina, 1966; seeking location in Gadsden area or in southern part of state in town of 5-7,000 population; available July 1, 1971. LW-7/1

Age 60, University of Arkansas 1932, seeking location for general or industrial practice. LW-7/3

Age 34; University of Tennessee 1964; seeking associate practice. LW-7/5

Age 29; University of Missouri 1967; National Board, seeking associate or solo practice in city of 50,000 or less population in south Alabama. Available July 1970. LW-7/6

Internal Medicine—

Age 59, Cornell University 1933, American Board certified, seeking group practice. LW-8

Age 31, Medical College of South Carolina 1964, Available July 1970. LW-9

Age 37, Duke University, 1956; Board certified, seeking group, associate, or institutional practice. LW-13

Age 33; University of Miami 1962; Board eligible; National Board; seeking solo, group practice, hospital practice, or industrial practice. LW-13/1

Age 31; Medical College of Georgia 1963; seeking location for practice of internal medicine-cardiology. Available 1970. LW-13/2

Neurology—

Age 32, Medical College of Georgia, 1964, seeking assistant or associate, or institutional practice. LW-14

Age 31; Harvard 1962; Board eligible; National Board; seeking solo, group or associate practice. LW-15

Age 29, Indiana Univ., 1964; Board eligible; seeking assistant or associate practice in city of over 100,000 population. LW-17/1

Obstetrics-Gynecology—

Age 49, University of Nebraska, 1943; Board certified, seeking group or institutional practice. LW-19

Age 34, Medical College of Virginia, 1961, Board eligible, seeking group or associate practice. LW-20

Age 33; University of Illinois, 1964; seeking associate practice. LW-21

Ophthalmology—

Age 33; St. Louis University, 1962; seeking solo, or associate practice. LW-21/1

Otolaryngology—

Age 32, University of Pennsylvania 1962, seeking associate practice. Available April 1970. LW-21/2

Pathology

Age 32, University of Louisville 1966, seeking associate or institutional practice. Available July 1970. LW-21/4

Age 52; New York State University 1940; American Board certified; National Board; seeking institutional practice. Available immediately. LW-21/5

Age 48; George Washington University 1947; National Board, American Board certified; seeking industrial, institutional, or associate practice in Birmingham, Montgomery or north Alabama. LW-21/6

Radiology

Age 28; Northwestern University 1964; completing radiology residency. Available July 1971. LW-24

Age 43; Louisiana State University 1953; Board certified, seeking associate practice, preferably in southern section of state. Available January 1970. LW-24/1

Surgery—

Age 33; University of Missouri, 1961; seeking group or associate practice. LW-27

Age 38; Emory University, 1956; Board eligible, seeking group, associate, or institutional practice. LW-28

Age 36, Indiana University 1961; Board eligible; seeking practice in city of 100,000 plus population. LW-31/1

Age 37, University of Paris 1961; seeking group or institutional practice in city of 80,000 plus population. LW-31/2

Age 48; Marquette University 1943; Board eligible; seeking institutional practice in east Alabama. LW-31/3

Age 31; St. Louis University 1963, American Board certified; seeking associate practice. LW-31/3

Age 48; University of Pennsylvania 1950; Board eligible; seeking solo or group practice. LW-31/4

Locations Wanted

Age 31; Medical College of Alabama 1963; American Board certified; seeking associate practice. Available July 1970. LW-31/4

Age 36, Emory University 1959, Board certified, seeking associate practice. Available September 1970. LW-31/5

Urology—

Age 30; Louisiana State University, 1963; Board eligible, seeking associate, or group practice. LW-32

Age 31, Chicago Medical School 1963, seeking associate practice in Montgomery. Available July 1970. LW-32/1

Student Health—

Age 40, University of Oklahoma 1955, seeking institutional practice. LW-33

Physicians Wanted

Special Openings—

Student Health—additional position has just been authorized. Join staff of seven full time physicians plus mental health, and full laboratory, x-ray, physical therapy and dietary services. Negotiable salary. Excellent fringe benefits. Cultural advantages of University community. PW-18

General surgeon, Board certified, needs young associate to do general practice including obstetrics. Salary negotiable. PW-19

Two physicians, ages 39 and 40, are interviewing for a select individual to enter association in a university town of 80,000 population. Outstanding new physical plant. Readily available hospital privileges. Four and one-half day work week. Three free weekends per month. PW-19/2

Specialist in the following fields: Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practitioners. 58-bed fully accredited general hospital with 91-bed addition recently completed. Modern new office space available. PW-20

Pediatrician, Internist, and ENT specialist to join a well-established group practice in a community of 40,000 in East Alabama. The community has a 125-bed accredited hospital, 32-bed extended care facility. Good transportation on interstate with quick access to metropolitan area. Will pay travel expense for interview. PW-20-1

Opportunity for ENT, Internal Medicine, and Orthopedic Surgery practitioners to join partnership at clinic located in city of 38,000 population in trade area of 150,000 population in northeast Alabama. PW-20/2

Internists, Board-certified or eligible. One needed now and another in 1 or 2 years. For early partnership with internist in south Alabama city of 40,000 plus population. New office building adjacent to 181-bed hospital. Practice largely hospital in-patient and Cardiology. PW-21

Opportunity for a Board certified or eligible surgeon to be associated with a Board surgeon in city of 150,000 population. PW-21/1

The Alabama Department of Mental Health is seeking several physicians. Vacancies exist at Bryce Hospital, Tuscaloosa, and Searcy Hospital, Mt. Vernon. PW-22

General Practitioner or Internist for associate or separate practice in Birmingham. Modern office space and excellent hospital facilities. PW-26

Obstetrician-Gynecologist—

Excellent opportunity for a trained Ob-Gyn man, who would join a two-man partnership in city of 30,000 population located in south central Alabama. Salary is proposed for the first year, with partnership thereafter. PW-25

General Practitioners—

For town of 2,000 population located in trade area of 15,000 population in northeast Alabama. Nearest metropolitan centers 30 miles distance. Industrial area. Clinic and some office equipment available. Several churches, schools, and civic clubs. PW-23

Opportunity for GP to join well established four-man partnership; three general practitioners and one board certified surgeon. Practice located in city of 8,000 population, trade area of 60,000, north-central Alabama. Modern new partnership-owned offices adjacent to modern 125-bed fully accredited hospital. Salaried first year with possible partnership status at end of first year. PW-27

Opportunity in town of 4,000 population in trade area of 50,000 population, located within 100 miles of two metropolitan areas in south Alabama. Industrial and farming area. 44-bed hospital. Office space and equipment available in new building with another physician. Several churches, schools, and service clubs. PW-1

For community of 1,500 population located in south Alabama near city of 12,000 population. Hospitals located within 25 miles. Office space and equipment available. Farming, cattle and textile industries in the area. Several churches and school. Civic clubs and golf courses. PW-1-1

For town of 10,000 population in county of 40,000 population located in scenic mountainous section of Northeast Alabama. Office space and equipment available. Hill-Burton hospital-nursing home. Expanding industries in top agricultural area. PW-1-2

For community of 2,000 population, plus large trade area, located in Southeast Alabama. Modern clinic, fully equipped. PW-1-3

Opportunity in port town of 1,000 plus population in population center of 10,000 located in Southeast Alabama. Clinic available. Hospital located less than 20 miles away. Recreational advantages for water sports. Expanding industrial and farming area. Churches and schools. PW-1-4

(Continued on Page 790)

Physicians Wanted

(Continued from Page 789)

For town of approximately 1,000 population in Northwest Alabama, near Tennessee Valley waterways. New 15-bed clinic available. Centrally located near metropolitan areas. Extensive industrial developments. PW-1-5

For town of 12,500 population in trade area of 50,000 located in South Alabama. Nearest large city with population of 145,000 is 80 miles away. Two hospitals with 140 beds. Numerous small industries. Several churches and schools. Recreational activities include water sports and golf course. PW-1-6

General Practitioner to join partnership in town of 3,000 population, plus trade area of 20,000 population in northwest Alabama. Modern office building with six examining rooms. Full partnership at beginning of third year. New 30-bed Hill-Burton hospital. Salary open. PW-1/7

Opportunity in community of 3,000 population with over 8,000 population in trade area, near metropolitan area in northwest Alabama. Clinic and office equipment available. New 400-bed hospital and older hospital, and several nursing homes. PW-1/8

For town of 2,000 population in trade area of 7,000 population located in west Alabama. Physician recently died. Nearest city is 30 miles away. Medical facilities include Hill-Burton hospital and nursing home. Churches, schools, civic clubs, and recreational advantages. PW-1/9

For town of 1,800 population located in southeast Alabama in a population center of 10,000 population. PW-1/10

For town of 7,000 population located in population center of 15,000 population located in northeast Alabama. Office space and equipment available. Hospitals located in adjoining towns within 12 miles. State University located in the town. PW-1/11

For town of 2,500 population located in northeast Alabama. 17-room modern brick clinic fully equipped. Hospital nearby. Excellent schools and recreational advantages, water sports. PW-1/12

For town of 5,000 population, located in northwest Alabama. 55-bed hospital being completely renovated, and an adjoining 69-bed nursing home. PW-1/13

Opportunity in well situated central Alabama county, trade area of 18,000 population, manufacturing, mining, farming region. New office building furnished. 33-bed accredited hospital. Excellent recreational facilities including new country club. PW-1/14

Opportunity for group practice in town of 10,000 population in north Alabama. PW-2

Physician wanted to join 39 year old Medical College of Alabama graduate in a well established general practice in West Central Alabama town. Salary initially followed soon by full partnership. PW-3

Opportunity in community of 2,500 population in trade area of 8,000 population located 20 miles from metropolitan center in north Alabama. Proposed medical center development. PW-4

Physician wanted to join well established partnership in Northwest Alabama city of 15,000 population. Two accredited hospitals, junior college, schools, churches, recreational activities. No obstetrics or surgery. New office building. PW-7

For city of approximately 15,000 population in north Alabama, with trade area of approximately 45,000 population. Hospital with over 100 beds, and expansion planned for next year. Nursing homes in the area. Industrial growth and agricultural region. Several churches and schools. Golf course, civic and fraternal organizations. PW-8

For city of 5,000 population located 80 miles northwest of Birmingham. Industrial area. JCAH certified hospital facilities of 70 beds. Office space available for $200 per month. Guaranteed income. One physician in city desires partner, no investment, or associate. PW-1/15

For community of 2,000 population located in central Alabama, 30 miles southeast of Birmingham. Farming area. Clinic available. PW-1/16

For town of 3,600 population in trade area of 5,000-7,000 within 100 miles of two large cities and the Gulf Coast. 50-bed hospital located in the town. Office space available. Agricultural and expanding industrial area. Several churches and two schools. Recreational activities in the town as well as nearby—golf course, hunting and fishing. PW-17

Unusual opportunity for two general practitioners with military obligations satisfied at a modern fifty bed facility located 15 minutes drive from largest metropolitan center in north-central Alabama. Construction of a new two-story office building is scheduled to begin soon. PW-18

Opportunity in city of 5,000 population located in Northeast Alabama in trade area of approximately 10,000 population. Office space available. One physician died recently. Hospital and nursing home in the city. PW-19

Hospital based professional association in suburb of Birmingham is seeking a young general practitioner who has completed military obligation. High income, profit sharing, paid vacation and retirement plan. Complete facilities available. No investment required. PW-19/1



Rising Medical Care Costs--What To Do?

The recent National Pharmaceutical Council Symposium on "Meeting Health Care Costs" was moderated by Ray E. Brown, Executive Vice-President of Affiliated Hospital Centers of Boston and Professor of Administration at Harvard University. Mr. Brown was formerly with the American Hospital Association and was also on the faculty of the University of Chicago.

Medical care costs and especially hospital costs are high and are going higher. This statement and others like it comprised the theme, the main discussion and the summary and conclusions of the Symposium.

Mr. Brown was the keynote speaker. He introduced the subject by presenting an analysis of hospital costs. He emphasized that the rate of increase in health care expenditures was exceeded only by the concern which the problem had generated.

He thinks that many factors have coincided to magnify the problem and bring it to public attention. The growth of plans for collective payment for health care has amalgamated the financial totals and made the health budget more visible. The war against poverty and the war in Vietnam have constituted unusual demands on public funds with a reciprocal decrease in resources for medical care. Inflation has robbed the health budget of some of its wealth. These factors, together with the fact that aspirations for health have been overbuilt and the realization that money won't do everything have occurred simultaneously to emphasize an ideological conflict with the voluntary system. Discontent in these matters is voiced by a small but knowledgeable and vocal segment of the population.

Prof. Brown is sure that the costs will continue to increase. In the past five years the nation has gone from an expenditure of $33.6 billion (5.2 per cent of the gross national product) to $55.5 billion which is 6.3 per cent of the GNP. By 1975 he expects the bill to be $94 billion or 7.5 per cent of the GNP.

Change, if there is to be any, must be made in the health care system. He thinks it is not possible for individual institutions to reform, each by itself.

One method Mr. Brown suggests to limit hospital costs is to limit the supply. There is practically no limit to the utilization of acute care beds if they are built without limit. The biggest need now is for convales-

cent, limited care, and nursing home facilities. He suggests the possibility of public control of the number of hospital and nursing home beds by a franchise system similar to that which regulates the establishment of banks.

Utilization control can be improved. There are regional differences in the length of hospital stay for common conditions which amount to as much as 2-1. These are average figures for uncomplicated cases. One region in the U. S. uses twice as many hospital days for obstetrical cases as another, both with excellent results. Uniformity, presumably by shortening the customary stay in some regions, will lower the hospital bill.

Mr. Brown emphasizes that labor costs are the biggest part of hospital expenses, and that unionization is growing and will increase hospital wages. Annual statewide bargaining for hospital wage rates, as is done in Minnesota, provides a method by which the public may help decide the wage question.

All medical institutions will save money—as much as $500 million annually for the nation—by giving up item-posting in their bookkeeping. Most hospital expenses are prepaid by paying standard premiums, the size of which is determined by averaging. Hospitals may fairly determine an individual patient's bill by the average method, charge an average daily rate regardless of the number of hypodermics, dressings, laboratory tests, X-Rays, or intravenous medication and regain, for the total number of patients, the same amount of money they receive now by keeping books by itemization. Charging by the average is as equitable as paying insurance premiums by the average, and a lot more economical.

Mr. Brown refers to the above mentioned $500 million as money which is a part of the annual medical care bill but which does not represent any part of the medical service. Another item in the same classification is the money it costs to keep books on co-insurance and deductibles. Both of these insurance principles, says Mr. Brown, are desirable, since their use serves to limit utilization and total expenditures. However, since the effect of co-insurance and deductible payments can be averaged there is no need to keep books on each patient to obtain the same effect. A set percentage may be determined to represent the effect of both co-insurance and deductibles, and in the bookkeeping department this standard deduction may be applied to all parts of the bill with a very simple bookkeeping procedure. The annual saving which would accrue from this one change is variously estimated as between $700 million and $1100 million.

James H. Cavanaugh, Ph. D., Deputy Assistant Secretary for Health and Scientific Affairs, HEW, outlined the concern of President Nixon for the state of health care in general. The President considers that the health care system is in deep trouble, that this is not generally appreciated, and that radical changes will be required. Dr. Cavanaugh expressed the opinion that family planning should be developed as rapidly as possible. He also thinks that the quality of medical care should be improved, but questions whether quality care can be extended to all, and whether such care on a wide scale could be paid for.

George P. Hager, Jr., Dean of the College of Pharmacy at the University of North Carolina, paid tribute to the pharmacist as a highly dedicated professional who contributed heavily to the value of pharmaceutical services by attention to prescribing rules and laws. Dr. Hager emphasized that drugs are the biggest bargain in the health care budget.

Harold G. Pearce, Senior Vice-President for External Relations of the Blue Cross Association, pointed out that the health care industry is now the nation's third largest. It may be the largest by 1975. The prepayment plans now cover, in part, 85 per cent of the population but actually pay only 35 per cent of the total bill. The future will see an increase in demand for comprehensive care under

insurance. National health insurance is a possibility. The income tax credit program of the AMA is in good repute at the present time.

Dr. Gerald Dorman, President of the AMA, noted that the portion of the health care bill which is paid by the government is increasing. He emphasized that the non-medical factors which affect health—housing, trash disposal, pollution—are as important as medical care. He thinks that the problems in health vary in the various states and that one system for the entire nation will not be feasible. He said that the big problems of the medical profession were the few doctors who were unprincipled, the enormous increase in malpractice actions and the cost of malpractice protection. He emphasized the importance of research and continuing education. He observed that, while the emphasis today is on preventive medicine, the interest in preventive measures is low, and especially in the slums, where it is probably needed the most.

New Type Anesthesia May Prove Major Discovery

A new type of anesthesia developed at Alabama's Medical Center, described by Dr. Guenter Corssen, professor and chairman, Department of Anesthesiology, University of Alabama School of Medicine, produces the relaxing and pain-killing effects of many well-known drugs, without the inherent dangers to the central nervous system feared by most anesthesiologists. Called neuroleptanalgesia, from several Greek words indicating freedom from pain because of the "shutdown" of certain nerves, the anesthesia combines a highly effective tranquilizer with a pain-killer. Specifically, it represents one of the first successful efforts to effect selective blocking of certain nerve paths involved with pain conduction and perception, while avoiding total depression of central nervous system activities.



Dr. Corssen

The purpose of anesthesia, of course, is to prevent pain during surgery. However, many anesthetic agents or methods can be as dangerous as they are beneficial, particularly if the patient is very young or very old, or in a generally weakened physical condition. The danger lies in the anesthesia's effect on vital bodily functions; i.e., while it is blocking out the nerves which transmit pain, it may also depress important activities and protective mechanisms of the body.

For years, anesthetists have been searching for new types of drugs to abolish pain without the undesirable side effects which can be catastrophic if not carefully controlled. Naturally, of particular concern are the maintenance of an unimpaired heartbeat and undisturbed breathing. The new neuroleptanalgesia, now being used on surgical patients at the UAB Medical Center, is a promising approach to these problems, according to Dr. Corssen.

Contained in the anesthesia is the potent tranquilizer droperidol, which "not only calms the mind but helps to prevent nausea and to preserve the body's physiologic balance." The analgesic, or pain-killer, is fentanyl, a narcotic drug which Dr. Corssen says is probably the most powerful narcotic-pain-medication known to clinical medicine. The two drugs cause fewer side effects than any others tried, and have a more rapid onset and shorter duration of action, providing optimal control.

Because the patient is not put into a deep

sleep with neuroleptanalgesia, he can respond to simple questions and directions from doctors and nurses, without recollection upon awakening. This feature is invaluable where the cooperation of the patient is necessary during surgery. Should a general anesthesia be required, the anesthesiologist may simply put the patient to sleep with a small amount of mild general anesthetic such as nitrous oxide—commonly known as "laughing gas." This light anesthesia is enough for almost any kind of surgery, and it avoids the risks that deep anesthesia places on vital functions, Dr. Corssen says.

Probably the best feature of neuroleptanalgesia is that it does not depress the heart action; in fact, it helps to maintain good blood flow by slightly expanding peripheral blood vessels.

"Any adverse effects that may occur with neuroleptanalgesia can easily be controlled by techniques familiar to the anesthesiologist," Dr. Corssen said. For example, a muscle-relaxing drug may be needed to counteract the patient's rigidity, or another medication to counteract a drop in blood pressure. But most additionally needed drugs are safe for any patient, he indicated.

Dr. Corssen feels that the new anesthesia is a particular boon to many "poor-risk" patients who could not otherwise receive the benefits of major surgery, and in general is relatively simple, safe and effective for many different kinds of operations.

Does World Whirl Toward Full-Scale Famine By '75?

We were warned in 1798: "Population, when unchecked, increases in a geometrical ratio. Subsistence increases only in an arithmetical ratio. A slight acquaintance with numbers will show the immensity of the first power in comparison of the second."

The alarm, terrifying in its simplicity and import, came from England's famed political economist T. R. Malthus. It was little heeded.

Only one hundred and seventy years later, physicist-writer C. P. Snow, in a lecture at Westminster College, remarked: "I have to say that I have been nearer to despair this year, 1968, than ever in my life. We may be moving—perhaps in ten years—into large scale famine. Many millions of people are going to starve. We shall see them doing so upon our television sets."

The number of people on earth has grown with Malthusian speed. There were only 250 million people living at the time of Christ. It took all of sixteen centuries for that population to double to 500 million people. At the rate we are going now, it will take only about 25 years for our present population of 3½ billion people to double to 7 billion.

Food supplies lag far behind. The world's production of food today is not adequate—in quantity or quality—for even 3½ billion people. To feed another 3½ billion hungry mouths only 25 years from now will require enormous increases in food supplies.

Population biologist Dr. Paul Ehrlich of Stanford believes "it is already too late to prevent a drastic rise in the death rate through starvation." Others predict full scale famine by 1975.

In spite of warnings, the world seems to have been taken by surprise. People of every nationality and economic circumstance now face a common enemy, for widespread famine endangers nothing less than civilization itself. As Ehrlich puts it, ". . . saying that the population explosion is a problem of underdeveloped countries is like telling a fellow passenger 'your end of the boat is sinking.'"

To solve the world food crisis, if it can be solved, extraordinary efforts will have to be made to develop and implement an advanced food technology.

—Syntex Corporation
Annual Report

Alabama Department of Public Health

Darkfield Microscopy Quickly Diagnoses Syphilis

A quick diagnostic service for syphilis is being offered private physicians by the Alabama Department of Public Health. Already on the decline in Alabama, the syphilis case rate is expected to drop still lower with rapid detection afforded by darkfield microscopy.

Dr. Frederick S. Wolf, director of the Bureau of Preventable Diseases, noted in a letter to physicians recently that Alabama "is experiencing its fourth consecutive year of reduction in reported syphilis. Reported primary and secondary syphilis has been reduced 73 per cent since 1965. This has been accomplished through a team effort of private medicine and the Alabama Department of Public Health venereal disease program. To continue the decrease in reported syphilis requires continued cooperation and more rapid epidemiology."

Darkfield microscopy makes possible a rapid, highly accurate diagnosis of syphilis. It is superior in many respects to the more commonly used blood test, especially in the primary stage.

A two-day workshop was held for 16 public health representatives employed in venereal disease control. The workshop was conducted by Ernest Creighton and Edward Kennedy of the National Communicable Disease Center Venereal Disease Research Laboratory, Atlanta. They were assisted by Mrs. Ruby Atkins, head of the serology division of the Bureau of Laboratories, and microbiologist James M. Richard.

At the workshop held in the central public health laboratory, the VD field workers learned to operate the darkfield microscope and to identify the spirochete which causes syphilis. When exudate from a suspected



Photo No. 1—Phillip Moncrief, public health representative in the Mobile district, prepares a slide for viewing through the darkfield microscope. Sixteen VD field workers participated in a workshop recently.

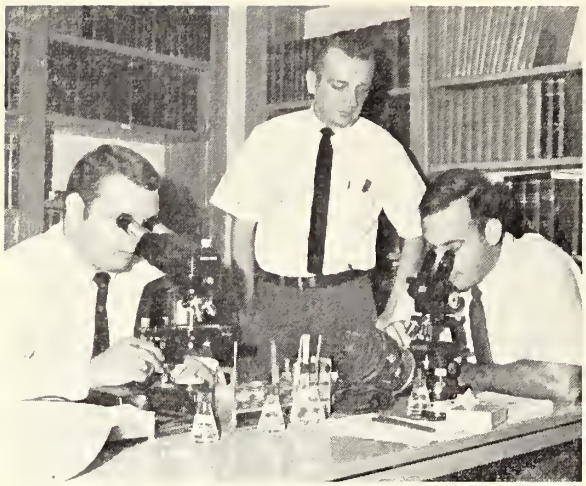


Photo No. 2—Robert Keeffe of Decatur and Bill Reed of Mobile look for TREPONEMA PALLIDUM, the syphilis spirochete, under the supervision of Ernest Creighton (center) of the CDC Venereal Disease Research Laboratory.

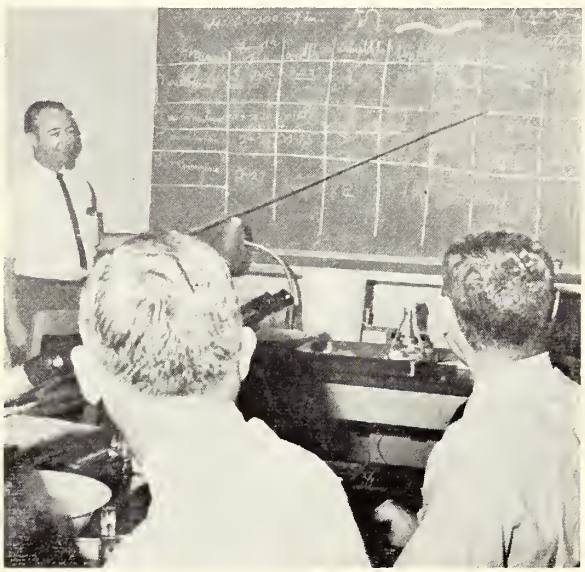


Photo No. 3—Edward Kennedy of the CDC Venereal Disease Research Laboratory points out characteristics of the spirochete which causes syphilis.

syphilitic lesion is placed under the microscope, particles in the fluid appear brightly illuminated against a black background. The syphilis spirochete—*Treponema Pallidum*—is identified by its size and other characteristics, but its most distinctive characteristic is its corkscrew shape.

Most physicians' offices are not equipped

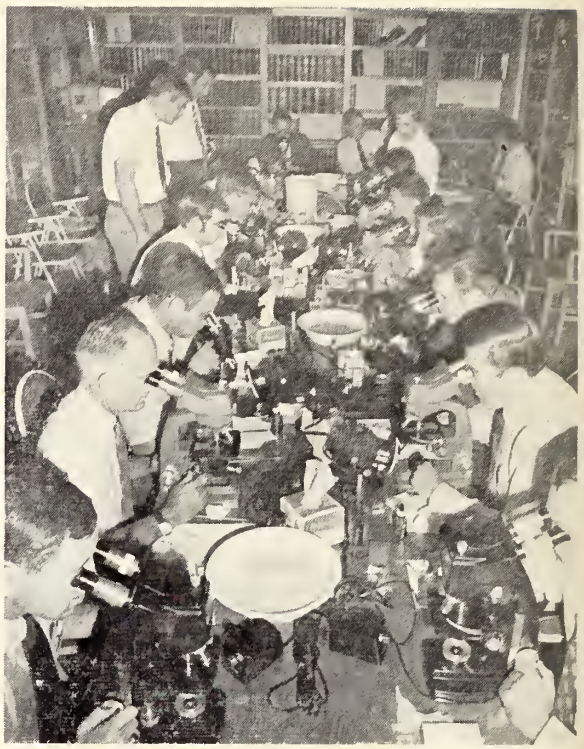


Photo No. 4—At the workshop held in the central public health laboratory, the VD field workers learned to operate the darkfield microscope and to identify the spirochete which causes syphilis.

with a darkfield microscope. It represents a substantial investment—approximately $1,000—and is not used for any purpose other than diagnosing syphilis.

Now, however, a telephone call from a physician will bring a technician and microscope to the physician's office. The service is available seven days a week, around the clock.

The public health representatives are assigned to districts and are not more than an hour's drive from any point in Alabama, estimates John Hill, senior public health advisor. VD field workers with darkfield microscopes are located at county health departments in Birmingham, Mobile, Montgomery, Tuscaloosa, Anniston, Evergreen, Dothan, Decatur, Huntsville, and in the central office of the State Health Department.

Darkfield microscopy has two distinct advantages over serological testing:

—The results are known within minutes,

enabling the physician to initiate treatment immediately while the patient is still in his office and precluding the infection of other persons. The results of a blood test are not known for at least 24 hours.

—A darkfield examination will detect the spirochete in the primary stage of infection. Antibodies are not always detectable in the blood of the infected person in the primary stage of syphilis.

There is also a possibility that a blood test will yield a false positive.

Alabama's case rate for 1968 is 9.7 per 100,000 population as compared to a 9.6 national average. Statistics based on the first nine months of 1969 indicate a 55.7 per cent decrease in primary and secondary syphilis when compared to the same period of 1968. The American Medical Association estimates, however, that only about 25 per cent of syphilis cases are reported.

Mr. Hill said the darkfield microscopy program is expected to create a better working relationship with physicians and to result in more complete reporting.

Darkfield microscopes are also being used in public health VD clinics.

DOCTOR—Do your juvenile diabetics know the benefits of Camp Seale Harris? Young diabetics aged 8-16 enjoy healthful recreation and diabetic instructions. Write for information:

Camp Seale Harris
Under auspices of
Alabama Diabetes Association
P. O. Box 8224
Jeanette Overstreet, Executive Secretary
Springhill Station, Alabama 36608

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

Laboratory Combined Division All Report for Period August, 1969

	No. Specimens Received
General Bacteriology	1,930
Virology	228
Parasitology	1,959
Enteric Bacteriology	349
Fluorescent Microscopy	4,663
Tuberculosis	4,647
Mycology	61
Milk and Dairy Products	5,505
Water	4,437
Sea Foods	14
Syphilis Serology	33,220
Special Serology	1,197
Metabolic Diseases	27,413
Cytology	3,074
Chemistries	206
Miscellaneous	820
Total Number of Specimens Received	89,723

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

Alabama Department of Public Health Laboratory

Combined Division Report for Period July, 1969

	No. Specimens Received
General Bacteriology	2,135
Virology	268
Parasitology	1,740
Enteric Bacteriology	351
Fluorescent Microscopy	4,224
Tuberculosis	4,811
Mycology	63
Milk and Dairy Products	5,598
Water	4,962
Sea Foods	43
Syphilis Serology	29,960
Special Serology	1,208
Metabolic Diseases	27,747
Cytology	2,542
Chemistries	166
Miscellaneous	983
Total Number of Specimens Received	86,801

BUREAU OF VITAL STATISTICS

PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA

Ralph W. Roberts, M. S., Director

October 1969

Live Births / Deaths / Causes of Death	Number Recorded During October 1969			Rates* (Annual Basis)		
	Total	White	Non-White	1969	1968	1967
Live Births	5,705	3,776	1,929	18.4	18.2	18.7
Deaths	2,520	1,716	804	8.1	8.3	9.0
Fetal Deaths	96	45	51	16.5	18.2	18.6
Infant Deaths—						
under one month	91	48	43	16.0	12.1	18.4
under one year	130	63	67	22.8	18.2	26.4
Maternal Deaths	2	.....	2	3.4	1.8	0.3
Causes of Death						
Bacillary dysentery, amebiasis, 004, 006	1	.....	1	0.3	.....	.....
Enteritis, other diarrheal diseases, 008, 009	8	2	6	2.6	†	†
Tuberculosis, all forms, 010-019	16	9	7	5.2	6.6	8.3
Diphtheria, 032	.....	.....	.....	.....	0.3	0.7
Whooping Cough, 033	.....	.....	.....	.....	.....	.....
Meningococcal infections, 036	1	1	.....	0.3	0.3	0.3
Poliomyelitis (acute), 040-043**	.....	.....	.....	.....	.....	0.3
Measles, 055	1	1	.....	0.3	.....	.....
Syphilis, 090-097	.....	.....	.....	.....	1.3	1.7
Malignant Neoplasms, 140-209	384	278	106	124.0	126.8	125.9
Diabetes Mellitus, 250	53	31	22	17.1	18.0	18.2
Major cardiovascular diseases, 390-448	1,274	910	364	411.5	†	†
Diseases of heart, 390-398, 402, 404, 410-429	880	643	237	284.2	272.2	290.2
Rheumatic fever & heart, 390-398	15	10	5	4.8	†	†
Hypertensive heart & renal diseases, 402, 404	22	11	11	7.1	†	†
Ischemic heart disease, 410-414	761	568	193	245.8	†	†
Cerebrovascular disease, 430-438	319	219	100	103.0	117.6	127.2
Diseases of the arteries, 440-448	64	43	21	20.7	21.0	24.1
Influenza, 470-474	.....	.....	.....	.....	.....	0.7
Pneumonia, 480-486	59	37	22	19.1	18.7	17.5
Bronchitis, emphysema, asthma, 490-493	23	19	4	7.4	†	†
Appendicitis, 540-543	3	2	1	1.0	0.3	0.7
Hernia, intestinal obstr., 550-553, 560	8	7	1	2.6	4.3	5.3
Cirrhosis of liver, 571	22	15	7	7.1	6.6	10.6
Complications of preg., childbirth, 630-678	2	.....	2	3.4	1.8	0.3
Congenital anomalies, 740-759	21	14	7	3.7	3.8	4.1
Immaturity, 777	21	10	11	3.7	4.5	4.6
Accidents, total, 800-949	180	133	47	58.1	58.6	65.1
Motor vehicle accidents, 810-823, 940	98	76	22	31.6	35.7	33.0
All other defined causes	324	196	128	104.6	109.1	123.3
Symptoms & ill-defined, 780-796	119	51	68	38.4	46.2	54.2

*Rates: Births and deaths—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

**Does not include late effects

†NOTE: The Eighth Revision of ICD (New Revised Code) is used beginning with January 1969. Comparison with statistics compiled under the former Code (Seventh Revision ICD) and rates cannot be made. Direct to the Alabama Bureau of Vital Statistics any question about comparability of statistics compiled and rates under the new vs. the former ICD.

BUREAU OF PREVENTABLE DISEASES

Frederick S. Wolf, M. D., Director

Current Morbidity Statistics

1969

	Oct.	Nov.	*E. E. Nov.
Tuberculosis	92	109	98
Syphilis	48	21	111
Gonorrhea	643	537	353
Chancroid	1	1	2
Typhoid fever	0	0	0
Salmonella	16	36	8
Undulant fever	0	0	0
Shigella	17	12	10
Amebic dysentery	1	1	3
Scarlet fever & strep. throat	873	1,093	258
Diphtheria	1	0	3
Whooping cough	1	6	7
Meningitis	16	19	6
Tularemia	0	0	0
Tetanus	1	0	1
Poliomyelitis	0	0	0
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	0	4	18
German measles	7	7	2
Chickenpox	16	20	15
Mumps	11	26	27
Infectious hepatitis	38	51	34
Typhus fever	1	0	0
Rocky Mt. Spotted fever	0	1	0
Malaria	1	3	0
Cancer	597	1,415	619
Rheumatic fever	11	14	14
Rheumatic heart	13	15	23
Influenza	85	181	83
Pneumonia	150	352	206
Rabies—Human cases	0	0	0
Pos. animal heads	2	4	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.



The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.



For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.



Contraindications: Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention), skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may b minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative derma-

Sandy sails again!
After an arthritic flare-up.

His rheumatoid arthritis flared out of aspirin control.
It meant weeks of pain, stiffness,
swelling and tenderness...and a lot of sun and wind that
somebody else took advantage of.

Next time, after aspirin, consider Butazolidin alka:
prompt anti-inflammatory effectiveness
short trial period
low maintenance dosage
usual dosage: 1 capsule q.i.d. initially, then 1 or 2 daily

Butazolidin® alka

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

Serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings and contraindications. Read the prescribing information. It's summarized below.

...s, Stevens-Johnson syndrome, ...ell's syndrome (toxic necrotizing ...idermolysis), or a generalized ...ergic reaction similar to serum ...ckness may occur and require ...rmanent withdrawal of medication. ...Agranulocytosis can occur ...ddenly in spite of regular, repeated ...rmal white counts. Stomatitis ...id, rarely, salivary gland enlargement ...ay require cessation of treatment. ...Such patients should not ...ceive subsequent courses of the ...ug. Vomiting, vertigo and languor ...ay occur. Leukemia and leukemoid ...actions have been reported. While ...t definitely attributable to the ...ug, causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria, glomerulonephritis and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Rheumatoid Arthritis: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily. In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response. (B)46-070-C

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502



If it doesn't work in a week, forget it.



symptoms of mixed anxiety-depression are rarely clear-cut...
but they are often a clear indication for

Mellaril®
(thioridazine)
25 mg. t.i.d.

effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69-384

Thank You, America

Permit me, a Canadian, to express a long overdue "thank you, America"—not only for putting men on the moon, but for almost 200 years of contributing to the betterment of mankind. For the airplane, radio, cotton gin, phonograph, elevator, movie machine, typewriter, polio vaccine, safety razor, ballpoint pen and zipper!

No other land in all the world has, in so brief a history, contributed so much and asked so little—only that we live together in peace and freedom.

From the days of Washington and Lincoln, you have demonstrated the creativity, invention and progress of free men living in a free society—where ideas and aspirations may be promoted to the extent of man's willingness to work and build a "better mousetrap" with commensurate rewards.

Thank you for upholding the principles and rights of freedom and liberty; for the American Constitution and Bill of Rights and for protecting those rights even when it results in the burning of your flag and the murder of your President.

Thank you for those who helped defend freedom on foreign soil in two world wars—a debt we have been able to pay in small measure by way of some 10,000 Canadian volunteers who stand and fight with you in Vietnam; for the foreign aid you give even when your hand is bitten and your motives impugned; for keeping your dignity in the face of insults from nations still wet behind the ears; for your patience with those who seek to steal the world and enslave its people; for keeping your cool even when the Trojan horse mounts the steps of the White House to insolently spew forth its treason.

Thank you for keeping alive the concept of individual liberty and faith in God in a world wallowing in humanistic collectivism.

For these reasons and so much more, I say: "Thank you America and God bless you."

Patricia Young,
Vancouver, B. C.

Reprinted from *Chicago Sun-Times* in *Illinois Medical Journal*

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: MRS. ELIZABETH HARKINS, ACSW, *Coordinator of Admissions* or

CHARLES W. NEVILLE, JR., M. D., *Assistant Professor of Psychiatry and Medical Director*

Area Code 704 - 254-3201

INDEX TO ADVERTISERS

Arch Laboratories 733

Blue Cross-Blue Shield 778

The Bradley Center 777

Breon Laboratories 741, 742, 743, 744

Burroughs Wellcome 799

Campbell Soup 761

Geigy 800, 801

Guest House Motel 746

Highland Hospital 803

Hoechst Pharmaceuticals 735

Hynson, Westcott & Dunning 725

Lederle Laboratories 727, 738, 747, 804

Eli Lilly & Company ..... 1st Cover, 748

Majorcan Carnival 787

National Drug Company ..... 2nd Cover, 731, 732

Parke Davis & Company 785, 786

Wm. P. Poythress & Co., Inc. 783

A. H. Robins 764, 769, 773, 774, 775, 784

Roche Laboratories ..... 729, 770, 4th Cover

Sandoz Pharmaceuticals 802

G. D. Searle & Company 762, 763

Smith, Kline & French Labs ..... 3rd Cover



in cardiac edema

Dyazide®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

gets the water out

spares the potassium

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported, in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium and BUN during therapy, particularly in patients with suspected or confirmed renal or hepatic insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—their combined use can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk; thus adverse reactions which have occurred in adults may occur in the fetus or newborn infant. Rarely, thrombocytopenia or pancreatitis has developed in newborn infants whose mothers had received thiazides during pregnancy. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

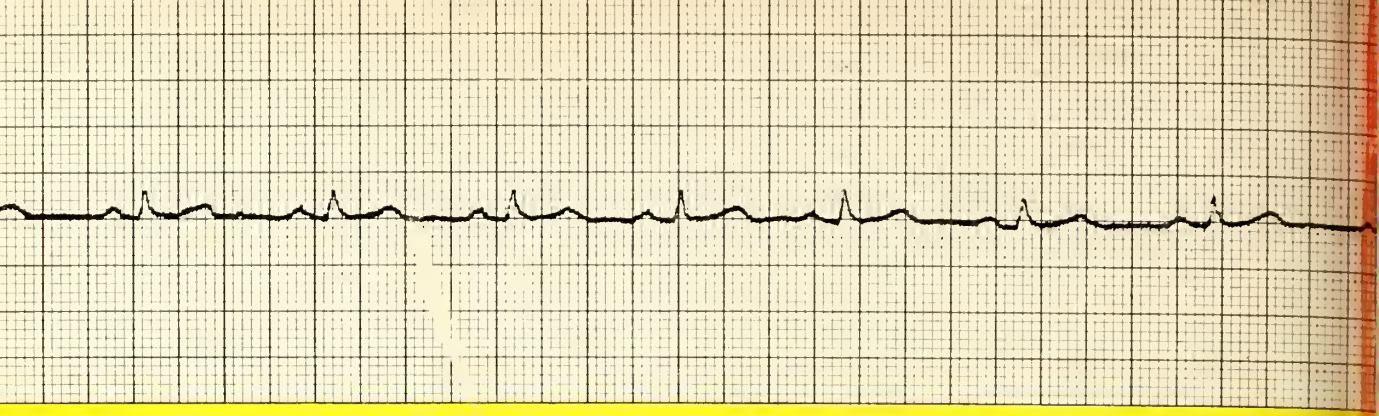
Precautions: Do periodic serum electrolyte determinations. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Adjust dose of antihypertensive agents given concomitantly.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, altered carbohydrate metabolism, hyperbilirubinemia, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

SK&F

Smith Kline & French Laboratories



When disease is ruled out and psychic tension is implicated

Valium® (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

JOURNAL of the Medical Association of the State of ALABAMA

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON
24 MAR 1970

DISPLAY
SHELVES

IN THIS ISSUE

Program - 46th Annual Convention of Woman's Auxiliary 809

Pylephlebitis and Liver Abscesses Following Appendicitis 831

Pulmonary Function Testing for the General Hospital and Physician (Part IV) 834



Francis A. Countway Lib. of
Medicine
10 Shattuck St.
Boston, Massachusetts 02115

MARCH 1970

The girth control pill



Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride)

works on the appetite not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. *Sympathomimetic cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. *Allergic phenomena* reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-006A / 1/70 / U.S. PATENT NO. 3,001,91

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 1914

LIBRARY OF MEDICINE
BOSTON
24 MAR 1970

LACTINEX®

TABLETS & GRANULES

■ **to help restore and stabilize the intestinal flora**

■ **for fever blisters and canker sores of herpetic origin**

Lactinex contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.[1,2,3,4,5,6,7,8]

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.

Baltimore, Maryland 21201

(LX-05)

References:
(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:9-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D.J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

THE JOURNAL

of the

Medical Association of the State of Alabama

Volume 39 • March, 1970 • No. 9

Office of Publication
19 So. Jackson St. — Montgomery, Ala. 36104
Subscription Price — $5.00 Per Year
$1.00 Per Copy

Second Class Postage Paid at Montgomery, Alabama. Published monthly in Montgomery at 19 South Jackson Street.

Editor-in-Chief
William L. Smith, M. D. — Montgomery

Managing Editor
L. P. Patterson — Montgomery

Assistant Managing Editor
Mary Nell Williford — Montgomery

Associate Editors
J. P. Collier, M. D. — Tuscaloosa
John M. Chenault, M. D. — Decatur
M. Vaun Adams, M. D. — Mobile

Officers of the Association

President
C. Kermit Pitt, M. D. — Decatur

President-Elect
S. Buford Word, M. D. — Birmingham

Vice-Presidents
F. M. Phillippi, Jr., M. D. — Brewton
J. E. Cameron, M. D. — Alexander City
O. Emfinger, M. D. — Union Springs
Wood S. Herren, M. D. — Birmingham

Secretary-Treasurer
William L. Smith, M. D. — Montgomery

Executive Director
L. P. Patterson — Montgomery

The State Board of Censors
John M. Chenault, M. D., Chmn. — Decatur
J. P. Collier, M. D. — Tuscaloosa
Hugh E. Gray, M. D. — Anniston
Paul W. Burleson, M. D. — Birmingham
L. L. Hill, M. D. — Montgomery
M. Vaun Adams, M. D. — Mobile
J. D. Bush, M. D. — Gadsden
E. L. Strandell, M. D. — Brewton
John W. Davis, Jr., M. D. — Montgomery
J. Garber Galbraith, M. D. — Birmingham

State Health Officer
Ira L. Myers, M. D. — Montgomery

Delegates and Alternates to the American Medical Association

(Terms expiring December 31 of year shown.)

1970
Delegate—E. Bryce Robinson, Jr., M. D., — Fairfield
Alternate—W. E. White — Anniston

1971
Delegate—M. Vaun Adams, M. D. — Mobile
Alternate—E. L. McCafferty, Jr., M. D. — Mobile
Delegate—P. W. Burleson, M. D. — Birmingham
Alternate—Robert Parker, M. D. — Montgomery

CONTENTS

President's Page — 808

46th Annual Convention of the Woman's Auxiliary to The Medical Association of the State of Alabama — 809

The Woman's Auxiliary — 810

Editorial Comment — 812

- Control of Drug Dependence May Become Impossible — 812
- . . . As Young As Your Faith, As Old As Your Doubt — 814
- When-You-Wind-Your-Watch Mightn't Be Soon Enough — 817

Association Forum — 819

- Peer Review Polishes Mirror For Improved Doctor's Image — 819

Majorcan Carnival — 829

Scientific Section — 831

- Pylephlebitis And Liver Abscesses Following Appendicitis, Harry J. Till, M. D., John M. Cameron, M. D., and Rcbert L. Dorrough, M. D., Montgomery — 831
- Pulmonary Function Testing For The General Hospital and Physician, Part IV., D. S. Tysinger, Jr., M. D., Dothan — 834

The Month in Washington — 845

Fathers and Sons in Medicine — 850

- "My Three Sons" Following in Their Dad's Footsteps — 860
- Three Gipsons, M. D., Scattered In As Many States — 851

Hcbbies To Fill A Doctor's Leisure — 854

- The City Dump May Hide A Treasure Trove! — 854

Bcoks of Interest to Doctors and Laymen — 857

Montgomery Doctor Flying "Instrument Rated" at 70 — 858

Around the State — 860

- Vital Statistics — 860
- New Physicians Licensed to Practice in Alabama — 865

1 of 10 in 50-Year Club — 870

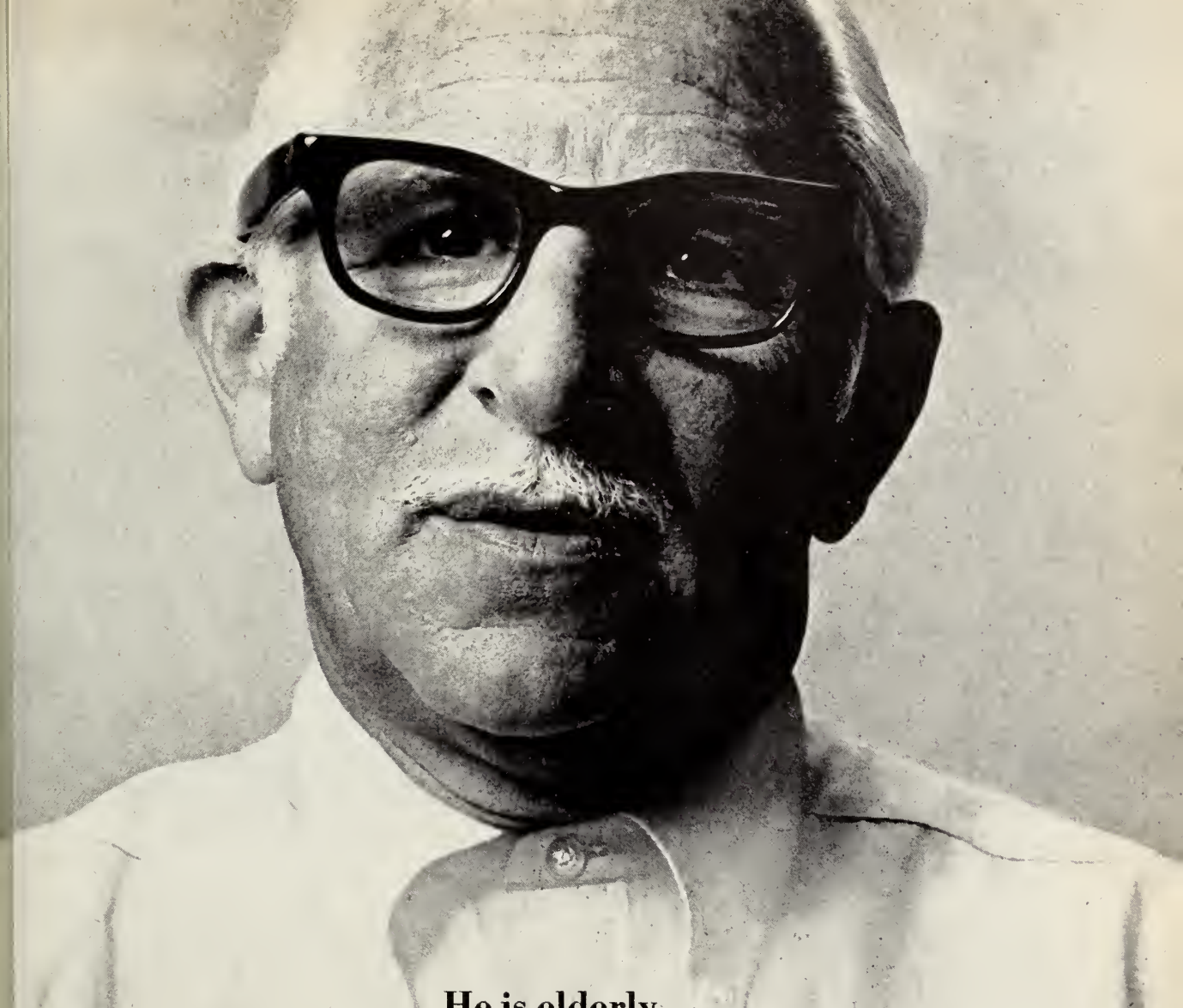
Alabama Department of Public Health — 875

- Huge TVA Nuclear Power Plant Checked for Pollution — 876

Physician Placement Service in Alabama — 880

ALAPAC Luncheon Speakers — 885

On ALAPAC Board — 885



He is elderly, he is on corticosteroids, when he needs an antibiotic he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

rd susceptible patients against intestinal monilial over-
n during broad-spectrum therapy—the protection of
in is combined with demethylchlortetracycline in
OSTATIN.

your susceptible candidates, prescribe DECLOSTATIN
broad-spectrum therapy that prevents monilial
owth.

ndication: History of hypersensitivity to demethylchlortetracy-
nystatin.

g: In renal impairment, usual doses may lead to excessive accumu-
nd liver toxicity. Under such conditions, lower than usual doses
cated, and, if therapy is prolonged, serum level determinations
advisable. A photodynamic reaction to natural or artificial sun-
s been observed. Small amounts of drug and short exposure may
an exaggerated sunburn reaction which may range from ery-
o severe skin manifestations. In a smaller proportion, photo-
reactions have been reported. Patients should avoid direct
e to sunlight and discontinue drug at the first evidence of skin
ort. Necessary subsequent courses of treatment with tetracy-
ould be carefully observed.

ions: Overgrowth of nonsusceptible organisms may occur. Con-
stant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES, A Division of American Cyanamid Company
Pearl River, New York

President's Page



C. Kermit Pitt

The 1970 Annual Session of the Medical Association of the State of Alabama will be in Mobile, April 30-May 2. Center of activity will be Mobile's spacious and beautiful Municipal Auditorium lacking nothing in convenience and attractiveness and surrounded by lovely architectural restoration interesting to survey.

The scientific sessions will deal with a variety of subjects of interest to all Alabama physicians and will feature several nationally known medical scientists and practitioners. Included among these will be AMA President Gerald Dorman; Duke University's Professor of Internal Medicine, Eugene Stead and Professor of Radiology Richard Lester; Florida Professor of Pathology and Pediatrician, Richard Smith; Pediatric Allergist Claude Frazier; and world renowned cardiovascular surgeon Denton Cooley.

The Jerome Cochran Lecturer will be Alabama's own Sterling Edwards, now Professor of Surgery at the University of New Mexico.

Heading the list of speakers from the University of Alabama School of Medicine will be S. Richardson Hill, Vice-President of Medical Affairs, W. A. Daniel, Jr., Professor of Pediatrics and Director of the Department of Adolescent Medicine; Charles Flowers, Chairman of the Department of Obstetrics and Gynecology and the brilliant young Max Cooper, Professor of Pediatrics and, among other things, expert in the field of immunologic diseases.

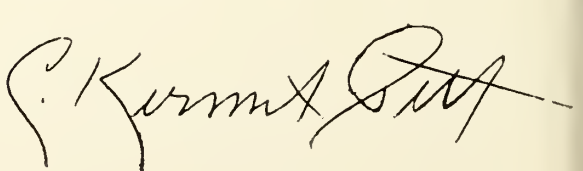
A unique feature of the program will be the appearance of a medical student, Mr. Ronald Merrell, who will do some breaching of the generation gap and relate his experiences with project Hope.

Friday Night's Awards Banquet will honor many people and will feature an address by the Governor of Alabama, the Honorable Albert P. Brewer.

Saturday morning will be devoted to business including a review of the past year's Association activities and election of officers.

The Medical Association of the State of Alabama belongs to every physician who is a member. It will continue to be as good or as mediocre as its members make it. Each has a contribution to make. None should hide his light under a bushel.

Let us dedicate April 30-May 2, 1970 to meeting our friends, enriching our minds and conducting the business of our Association in Mobile.



C. Kermit Pitt, M. D.

46th Annual Convention of the Woman's Auxiliary to the Medical Association of the State of Alabama

There are many outstanding features planned for the 46th Annual Convention of the Woman's Auxiliary to the Medical Association of the State of Alabama. On Thursday, April 30, Father Daniel Egan, author of "The Junkie Priest," will be the featured speaker at the luncheon to which the doctors are cordially invited. In addition to this distinguished speaker, we are proud to have with us Belle Chenault, National President of the Auxiliary, and Louise Peek from Baton Rouge, President of the Woman's Auxiliary to the Southern Medical Association.

On Thursday night the members of several of the County Auxiliaries will entertain the doctors and their wives with humorous skits. There is much talent among these girls you room with, and we are going all out on this entertainment which will be professional in quality.

The President's Luncheon for the Executive Board will be held on Wednesday at 1:00 o'clock at Holiday Inn, Convention Headquarters for the Auxiliary. The Luncheon will be followed by the Pre-Convention Board Meeting. On Wednesday night there will be a Dutch Treat dinner at the beautiful Bienville Club for the Board Members, if there are doctors who wish to join their wives and us, please do.

THURSDAY, APRIL 30

8:00 a.m.—5:00 p.m. Registration—Municipal Auditorium. Registration fee $2.00

7:30 a.m.—Seated Breakfast—Malaga Inn

8:30 a.m.—First General Session—Auditorium

Luncheon

3:00 p.m.—Second General Session—Auditorium

Dinner—Auditorium—Skits by Auxiliaries

Thursday at 5:00 p.m. is the deadline for Entries and Exhibits, a show open to members, husbands and children, for displaying talents in Photography, Arts, Crafts, Hobbies and Collections. These entries should be brought to the Auditorium where they will be on display in the lobby.

FRIDAY, MAY 1

8:00 a.m.—Continental Breakfast—Auditorium

8:15 a.m.—Third General Session and continuation of Continental Breakfast

12:00 —Adjourn Auxiliary Convention

Delegates urged to attend ALAPAC Luncheon

3:00 p.m.—Walking tour of shops and galleries in Convention area.

Awards Dinner

The Woman's Auxiliary

President, Mrs. Ben H. Johnson, Jr.
President-Eleet, Mrs. Howard C. Johnson
Northeast District Viee President, Mrs. James D. Holliman, Jr.
Northwest Distriet Vice President, Mrs. Gene Qualls
Southeast District Viee President, Mrs. George Andrews
Southwest Distriet Viee President, Mrs. Andrew D. Henderson
WAMASA Editor, Mrs. William L. Smith

AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the Medical Association of the State of Alabama. I will support its activities, protect its reputation and ever sustain its high ideals."



Mrs. Ben H. Johnson

The Health Careers Congress, co-sponsored by the Woman's Auxiliary to the Medical Association, Alabama League for Nursing, Alabama State Nurses Association and the Health Careers Council of Alabama, was held in Montgomery on February 5 and 6 at the Jefferson Davis Hotel. It was my privilege to attend this exciting event. Meeting with these hundreds of High School students, all interested in pursuing careers in Health related areas, was very stimulating. A film festival presented information on specific health career areas, and an election was held with the candidates for office putting on a real election campaign. The door prizes, a big attraction for the students, were furnished by donations from the County Auxiliaries throughout the state. We can certainly be proud of our efforts in promoting Health Careers for when there are this many interested, alert, good-looking, well turned out high schoolers you can't help but feel better about the generation coming on.

Despite the bad weather, I have traveled about the state; in Mobile for a meeting of the Convention Committee and to attend the luncheon meeting of the Auxiliary, and from there to Covington County, meeting with that Auxiliary. I was presented with a lovely orchid in Mobile, a rare one grown by a local doctor, and beautiful camellias in Andalusia. What fun.

In Montgomery I attended the meeting of Montgomery County Auxiliary where the ladies of Autauga County have been invited to join with Montgomery County to form the Montgomery-Autauga County Auxiliary. Congratulations to both groups.

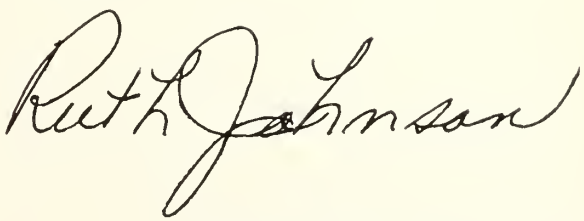
In Walker County the County Medical Society meets for dinner at People's Hospital, where the food is super, and the Auxiliary meets with them for dinner. Separate meetings are then held. This is an excellent plan, the doctor and his wife have a night out with a good dinner and make a meeting at the same time.

Visits to Talladega County, Pickens, Etowah, and Calhoun counties have filled my days. Everywhere I find Auxiliary members charming, busy, enthusiastic, and interested in Auxiliary projects. Membership is increasing and work is being done with Hospi-

tal Auxiliaries, Candy Stripers, and money raised for Nursing scholarships.

We are counting on all of you to participate in the Exhibits at the Convention and to bring your hobbies for display. The Archives and Exhibits chairman, Mrs. William P. Baston, 1221 W. Carre Drive, Mobile, is expecting to have many doctors' families participate in this part of the convention. The exhibits will be housed in the center foyer of the Auditorium, easily accessible for viewing by all. There will be Auxiliary members present and/or a guard at all times. So your objects will be safe, and many awards will be given.

The Auxiliary year is nearing the close of the 1969-70 administration, reports are due and with the work all done, we are looking forward to a NEW look at the convention. An outstanding speaker, a fun-packed Gaslight Party, VIP's Belle Chenault, our National President and Louise Peek, President of Southern Medical Auxiliary are on the agenda. We have a lot of business to come before the delegates, so let's all, doctors and their wives, plan for Mobile where so many events have been planned for your interest and pleasure.



(Mrs. Ben H. Johnson, Jr.)
President, WAMASA

Ostomy Association Of Birmingham

What's new in the Magic City? A great new group called the Ostomy Association of Birmingham! It is a non-profit, mutual aid organization composed of those who have experienced ileostomy, colostomy, ureterostomy and ileal conduit surgery. This organization is the first known group for ostomates in Birmingham and is one of almost 80 from all over the country which comprise the United Ostomy Association.

The purpose of this organization is to rehabilitate ostomates by providing many services to these people, their families and those who care for them. All of their assistance is free and the only charge is for dues which cover the cost of publications, mailing and the establishment of a Helping Hand Fund for indigents.

The Visiting Committee is available at the doctor's request to provide moral support and encouragement to new ostomates. Medical advice *is not* given. The Lecture Committee describes reactions to surgery when speaking to nursing groups. The bulletin, Semi Colon and the United Ostomy Association quarterly magazine, Ostomy Quarterly, keep ostomates abreast of the latest knowledge concerning care and rehabilitation. The club has a library of pamphlets and a display board of appliances and products to keep patients up to date.

The meetings are planned to enlighten members and give them current information in the ostomy field. The association meets the fourth Sunday of every month, except December, at the Veterans Administration Hospital, 700 South 19 Street, Room 968 B at 2:30 P. M. Membership is open to ostomates, doctors, nurses and their families and firends.

Dues are not required for those who cannot afford to pay. The Ostomy Association of Birmingham is sanctioned by the Jefferson County Medical Society and has a medical advisory board consisting of six doctors and a registered nurse is nursing consultant.

The enthusiastic members of this organization wish to provide services which will help their fellow ostomates find the key to the "fine art of living with an ostomy!" For more information, call 967-1194.

Mrs. Linda Gross
Co-Founder and President,
Ostomy Association of
Birmingham



Control of Drug Dependence May Become Impossible

"If drug taking for pleasure should ever become socially acceptable in this country and accepted as a harmless pastime, one could confidently predict that control of drug dependence would become impossible."

This single sentence, from the report of Henry Brill, M. D., to the Subcommittee on Education of the U. S. House of Representatives, is enough to frighten any responsible citizen (doctor or not) out of his lethargy.

Is the possibility remote? Or is the probability slapping us in the face?

For an approximate, paralleling example, one should turn back the calendar half a century. The ratified 18th Amendment was only months old. The 19th (granting nationwide suffrage to women) still awaited the required ratification by two-thirds of the 48 States.

The selling of rolled cigarettes was still banned in the State of Tennessee, bootlegged from behind the counter by otherwise respectable druggists. And the woman who smoked cigarettes in public was, rightly or wrongly, branded as beyond the pale of social acceptability.

In 1900 tobacco juice became the first product of the weed proved to cause cancer. But chewing was never a tidy habit and few women tried it.

A quarter of a century later pathologists began to notice an increase in the number of people with lung cancer. Before that fact was publicized widely, however, cigarette smoking for women became accepted socially. Instead of a few daring extroverts, mothers and sisters, wives and sweethearts began puffing their way beyond the point of no return.

Cigarette addiction, like alcoholism, may be equated with drug addiction.

One is filling the nation's cancer wards with agonized hosts and strapping oxygen tanks on the backs of uncounted thousands of emphysema victims.

Another is littering the nation's highways with the flaming tangle of automobile wrecks to the shattering music of ambulance sirens.

The third—returning our city streets to the jungle, making madmen, murderers and rapists of once docile masses—has captured our campuses to enslave our children and make a mockery of the once meaningful word: Education.

Dr. Brill is right. If drug taking for pleasure becomes socially acceptable, "a harmless pastime," the control of drug dependence becomes impossible.

(Continued on Page 814)



The pain of arthritis

relieved with MEASURIN® q. 8h. dosage

Double-strength Measurin timed-release aspirin offers a new kind of control for your arthritic patients. Each 10-grain tablet has over 6,000 microscopic reservoirs that release aspirin at a controlled rate—some right away and some later on. This means—fast relief, followed by long lasting relief. Throughout the day, Measurin gives your patients freedom from a 4-hour dosage schedule. Measurin can help your patients get a good night's sleep, uninterrupted by the need for an extra dose of aspirin. And, taken at bedtime, it also helps ease morning joint discomfort and stiffness.

For Professional Samples write:
Breon Laboratories Inc.
Sample Fulfillment Division
P.O. Box 141
Fairview, N.J. 07022

BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016
Subsidiary of Sterling Drug Inc.

MEASURIN®
TIMED-RELEASE ASPIRIN

ECONOMICAL • EFFECTIVE • LONG LASTING PAIN RELIEF
Dosage: 2 tablets followed by 1 or 2 tablets every 8 hours as required, not to exceed 6 tablets in 24 hours. For maximum nighttime pain relief and to help relieve early morning stiffness, 2 tablets at bedtime.
Available: Bottles of 12, 36 and 60 tablets.

(Continued from Page 812)

. . . As Young As Your Faith, As Old As Your Doubt

The joyous rhyming of an old Baptist hymn begins: "My faith looks up to Thee . . ."

The January editorial in *Alabama Family Physician*, by Carl A. Grote, Jr., M. D., editor, puts it this way:

"The problem with finding someone or something to believe in has never existed until recent years. In the past it was easy to find a person, institution, or organization in which you could have complete faith. Those were the people whom we set up as ideals. They set the example and made the rules by which one fashioned his life. If you conformed, you received certain benefits and rewards. If you did not conform, there was failure and punishment.

"Probably the greatest institutions were family, church, and country. They provided the main source of our rules and regulations by which we lived. They also provided the punishment (in one way or another) if we failed to live by these rules. . ."

The two adult generations, spanning the 40-year period between Hoover and Nixon, have permitted their leadership systematically to destroy our triune commitment to God, home and country, and thereby erase that other respected trio: Faith, hope, love. Dr. Grote, of Huntsville, who is also ALAPAC director for the 8th Congressional District, puts it this way:

"Young people today have a greater problem than you and I in finding someone to trust. Modern society is constantly bombarding these institutions as if to tear them from their roots. You never pick up a newspaper or listen to a newscast that you don't find items that shake your faith . . .

"Young people are constantly told not to trust the generations that have gone before them, for they are responsible for the mess the world is in today. So, they are frustrated and frequently lack direction, for they have no rule book or institution that they believe in strong enough to gain guidance from. They also do not feel that they should be punished by the rules for which they have only contempt, so they become further frustrated by attempts at discipline."

Dr. Grote then proceeds to pin the blame on the immaturity of those who have led us down the garden path:

"I have always thought that one of the best signs of maturity in a young person was when he quit looking at his parents as simply Mother and Father and began to know them as human beings. Then, he can accept their good points along with their bad and know that they react in human situations as human beings and not as bronze idols.

"The people who constantly try to tear down our society have not reached this level of maturity. They are striking out as a bewildered child would when he found out that his Mother and Father are not just roommates. He wants to leave home because he has realized what went on in the bedroom after dark.

"So, when you become infuriated with our youth today for their lack of faith in us, also have a little compassion—for remember, they also lack the security that you and I once had."

Or to put it as a philosopher in our young-old country once put it:

"You are as young as your faith, as old as your doubt; as young as your self-confidence, as old as your fear; as young as your hope, as old as your despair."

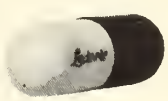
(Continued on Page 817)

Doctor, after all we've been through together...

abscess
acne
amebiasis
anthrax
bacillary dysentery
bartonellosis
bronchitis
bronchopulmonary infection
brucellosis
chancroid
diphtheria
endocarditis
genitourinary infections
gonorrhea
granuloma inguinale
listeriosis
lymphogranuloma
mixed bacterial infection
osteomyelitis
otitis
pertussis
pharyngitis
pneumonia
psittacosis
pyelonephritis
Rocky Mountain spotted fever
scarlet fever
septicemias
sinusitis
soft tissue infection
tonsillitis
tularemia
typhus fever
urethritis

...don't you think it's time we were on a first-name basis?

call me "Achro® V"



Every pharmacist knows ACHRO® V stands for ACHROMYCIN® V

Contraindications: Hypersensitivity to tetracycline.
Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.
Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).
Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage. Upon adverse reaction, stop medication and treat appropriately.

Achromycin® V
Tetracycline

Lederle LEDERLE LABORATORIES • A Division of American Cyanamid Company, Pearl River, New York 10965

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

(Continued from Page 814)

When-You-Wind-Your-Watch Mightn't Be Soon Enough

"Give as regularly as you wind your watch," urges the copyrighted slogan on a Church envelope for Sunday, Jan. 11, 1970. And the timepiece used to illustrate the injunction is of the pocket variety with a gold chain attached!

How long has it been since you saw such an antique?

Of course, one may smile at the slogan immediately and perhaps chide the minister with the reminder that present-day wrist watches are generally self-winding. But are you old enough to recall when a wrist watch on a man was a label of effeminacy?

Such gaudiness of then would have been equated with those eccentric beings of today who hide their masculinity behind finger rings, a chain around the neck, bell-bottom pants, and gorgeous locks flowing to below the shoulder, curling at the tip.

Isn't it the inverted swing of the metronome?

Or could we be wrong? And have we humans been reversing the order of nature, where the most colorful bird in the air is the cock? Where the most spectacular animal is apt to be the male?

There was a time, a few centuries back, when men wore wigs over their balding heads, when their fingers were heavy with rings, when pants were knee-length and coats were colorful, and where the finishing touch was apt to be a rapier suspended from the belt, its hilt aglitter with jewels. Monarchs wore ermine around the hem. And the law provided stiff penalties for the woman below the rank of nobility who wore a hat!

Wasn't that about the time, incidentally, when the doctor who lost a royal patient (whatever the disease and whatever the treatment) was guilty of malpractice?

And remember, there was no insurance then to cover his miscalculation. It's better to be alive today, with the inverted swing of the metronome.

The antique ticking timepiece should tell you: "It's later than you think."

Patients of Yesterday

Regulations of the Philadelphia General Hospital, 1790:—Patients may not swear, curse, get drunk, behave rudely or indecently on pain of expulsion after the first admonition. There shall be no card playing or dicing and such patients as are able shall assist in nursing others, washing and ironing linen and cleaning the rooms and such other services as the matron may require.

—Deleware Medical Journal

Taste!

Dicarbosil®
ANTACID

Your ulcer patients and others will love it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

Cardiovascular Problems

An "informal day of presentation of usual and unusual clinical cardiovascular problems with the demonstration of cardiac specimens," is planned by the University of Florida College of Medicine for Friday and Saturday, March 27-28, in Gainesville.

Jesse E. Edwards, M. D., is the featured speaker, and collaborating departments of the University are Medicine, Pediatrics, Surgery, Cardiac Radiology and the Regional Medical Program for North Florida, with the Alachua County division of the Florida Heart Association as co-sponsor.

Because of a conflict with another state meeting, this program, which is formally entitled "A Day of Cardiac Pathology with Jesse E. Edwards, M. D.," was changed from an earlier date.

Let's Reminisce!

Country Practice for Sale

An excellent Opening in one of the Richest Counties in Virginia. Price, $500 Cash, and $500 in One Year.

Ordinary Annual Receipts from Practice now are about $2,500.

Also property, specially suited for Practitioner's purposes, for sale, if wanted. Price $3,000. Address "County Practice" care Virginia Medical Monthly, Richmond, Va.

(Ad in Virginia Medical Monthly, July 1890)

To Feel is to Weep

One cannot be deeply responsive to the world without being saddened very often.

—Dr. Eric Fromm

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: MRS. ELIZABETH HARKINS, ACSW, *Coordinator of Admissions* or

CHARLES W. NEVILLE, JR., M. D., *Assistant Professor of Psychiatry and Medical Director*

SAMUEL N. WORKMAN, M. D., *Chief of Clinical Services*

Area Code 704 - 254-3201



Peer Review Polishes Mirror For Improved Doctors' Image

By Richard S. Wilbur, M. D.
(Assistant Executive Vice President, AMA)

(Paper read before Council of New England State Medical Societies, Boston, Text reprinted from Rhode Island Medical Journal)

Peer Review! A popular term these days. First, though, what does it mean? Literally it means a review by ones equals. Therefore, it means to us a survey of a doctor's work by other doctors.


Dr. R. S. Wilbur

Then why do we need this peer review so desperately? The answer to this question itself becomes a multiple series of problems. They begin, of course, with government — specifically with Titles XVIII and XIX which were passed in Public Law 89-97. While the Medicare Law only calls for in-hospital utilization review, experiences in the last 3 years have shown that far more is needed. There has been the well publicized increase in health care costs so that at the September meeting of the Medicare Health Insurance Benefits Advisory Council, the following statement was presented:

"In order to provide an acceptable level of quality for the services rendered under Part B of Medicare, consideration should be given to establishing standards to govern the rendering of services by physicians, analogous to, but necessarily quite different in application from, the standards now established for most other providers of health care under Medicare. The need for broad standards for physicians' services is predicated upon the right and responsibility of the government to have assurance of the acceptable quality of all services for which it provides reimbursement. Precedents which have been set in government and non-government programs, and published studies, which point out the wide variability in quality of medical care, indicate the need.

"Thus, the standards of eligibility for physicians would be a 'preventive' measure to keep some physicians from ever rendering certain medical services under the Medicare program. This differs from the 'post facto' stopping of abusers of

the Medicare program. The latter may involve a **few** physicians, those who are grossly abusing the program. The former could potentially involve the future participation of many of the practicing U. S. physicians in the rendering of certain medical services under the Medicare program."

The first answer to the "why" of peer review then is a very practical one. Government must be assured that it is getting its money's worth for all the billions it has spent with these large programs. No man can be elected to public office on a platform in which he agrees to allow the expenditure of unlimited and unchecked sums of money for any purpose—even for the health care of the American people. All of us here tonight are taxpayers and all of us would like to think that the money which we give up to our government is truly buying something worthwhile. The non-physicians of the country have been convinced by what they read in the newspapers that they are no longer getting their money's worth for taxes spent on Medicare and Medicaid. They want, rightfully, some proof.

There are still other reasons we need to have peer review. One is malpractice. This is an ever-growing problem in some areas such as Southern California where premiums of 5 to 16 thousand dollars a year are now being paid by doctors who have never been sued. The problem is acute. Over and over the point is made that the public is not assured that medical care is of high quality. Therefore, the allegations and accusations of the plaintiff's attorney fall upon open ears and juries are quite willing to believe the worst about all physicians. If they knew that an adequate mechanism of peer review existed which assured them of the quality of health care this problem could be alleviated as it has been in areas such as Tucson, Arizona.

The third reason why we need peer review comes from the press. The press has been quite willing to assign the responsibility for all of the rise in health care costs to the physician because it includes the vast portion which is paid to institutions, particularly the hospitals and extended care facilities. If we physicians are to take the blame for the expense, the least we can do is to take the responsibility for supervising this expenditure. In other words, we will have to supervise the utilization and, beyond that, even the efficiency and the quality of care given in the hospitals and the extended care facilities as well as that given by physicians. In some areas this review has been extended also to the ordering by physicians of such services such as physical therapy and even to the prescribing of medications— 95 per cent of health care expenditure.

The fourth reason, however, is the most important and that is the problem of satisfying the American people—the patients of the doctors of America—that they are receiving the highest possible quality of care. Let me say that I am not concerned about your particular patients. The mere fact that you are the kind of a physician who has enough interest to come here tonight to listen to a talk on this subject is proof enough that you are not the kind of a doctor whose patients need this assurance. Unfortunately, there are many other doctors who have not come here tonight and who don't go to any other medical meetings, conventions, or continuing medical education. These are the men whose patients are uneasy—sometimes with good reason. The question, therefore, becomes not if we need medical care review, but who will do it?

Review of Quality Under Medicare

The Cost Effectiveness Act of 1969, which has been sent from HEW to the House of Representatives, contains a number of provisions for federal review of quality under Medicare. Some of these include, as did also Walter McNerney's Medicaid Taskforce Report, suggestions for federal licensure and federal standards. So it now becomes very clearly a matter which will be handled by

government, if no one else steps forward first. However, we have seen in the past, situations in which the government was quite willing to accept voluntary standards. The Joint Commission on Accreditation and our specialty boards are two cases in point.

You might then ask whether there is any precedent for doctors in their organizations to engage in review of the quality of health care. There certainly is! The AMA virtually since its inception has been opposed to low standards as exemplified by quacks and chiropractors. Even before the Flexner Report, and certainly very much since then, we have been concerned with the quality of training in medical schools and with the accreditation of internship and residency programs. We have worked to improve the quality of drugs since 1900.

Within the local medical societies there have been rather elementary forms of peer review for many years. Most societies have some form of insurance review committee. This committee's activities vary from place to place, but in general, it adjudicates fees and makes some effort to explain why the fine print in an insurance contract means that the company does not have to pay the patient for the physician's work. Most local societies also have grievance committees. These, of course, take care of complaints, be they from patients, third parties or other physicians. Both of these types of committees are largely of the brush-fire type, i.e., they do not go into action until long after a problem has occured and not until after someone else brings it to the attention of the medical society.

Another form of peer review with which we are all familiar is that in the hospital with its credentials committee, medical records committee, tissue committee, and utilization review committees. The current AMA position on peer review can be summarized with the following quote from Report F of the Council on Medical Service to the Annual Meeting in New York this year:

> "For more than a decade, the Council on Medical Service and its Committee on Health Care Financing (formerly the Committee on Insurance and Prepayment Plans) have recognized a need for the establishment of professional review activities by medical society review committees and utilization review committees of hospital medical staffs. Initially, this interest was generated by concern over the continuing increase in the costs of health care, particularly for hospital services, and the resulting steadily rising rates required from the public for health benefits protections. In accepting a responsibility for professional review activities, the medical profession has demonstrated its awareness of the need to conserve the patient's health care dollar, educate and inform the profession in the economics of health care, assure the appropriate use of health care personnel and facilities, and maintain high standards of medical practice."

Future Outlook

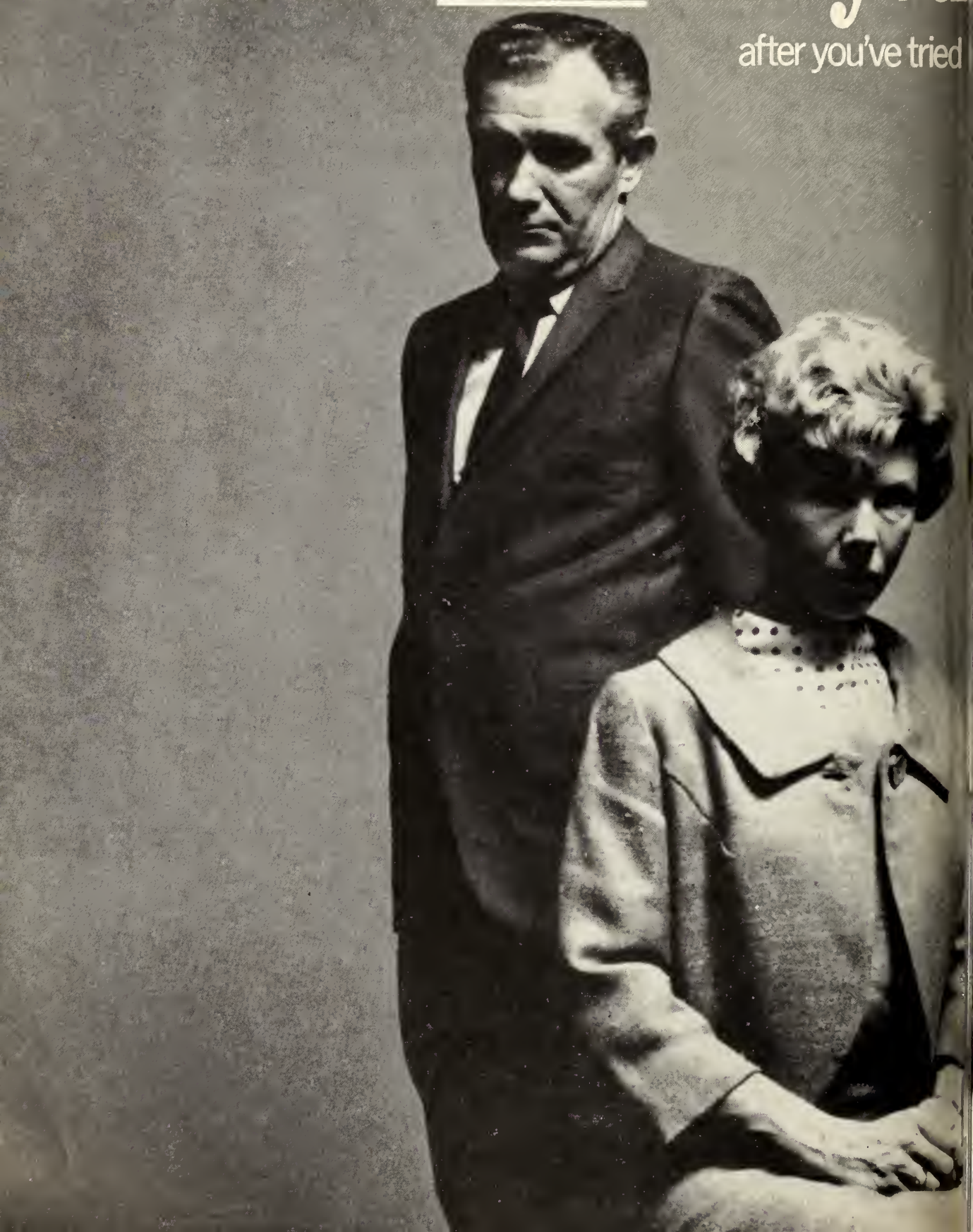
What is the future purpose of peer review then? Sometimes it is easier to start out by saying what it is not. It is not being a cop and it is not simply performing as a government agent to save tax money. The main purpose is to assure the public of the quality and effectiveness of the health care being given in that area. There are also side purposes of considerable importance, however, such as education. There is much which the person being reviewed can learn. As an example, the American Association of Medical Clinics in the last few years has set up an arrangement in which several doctors leave their practices in their different clinics and gather to spend 2 days inspecting a specific clinic. They do not do this as policemen who have been called in by the AAMC or by government to check on some questionable practices. They only do it when the clinic being surveyed requests such a visitation. In fact, the clinic which is surveyed pays all the expenses.

(Continued on Page 825)

in active stages of moderate to severe rheumatoid arthritis,

What more can you

after you've tried



heumatoid spondylitis, and osteoarthritis of the hip

do for these patients?

alicylates and rest



INDOCIN®

(INDOMETHACIN | MSD)

helps relieve pain, fever,
swelling, and tenderness

Please see new prescribing information on following page.



REVISED PRESCRIBING INFORMATION

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended under Indications. The drug should not be prescribed for children because safe conditions for use have not been established.

General Adverse Effects: Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg/day, without corresponding clinical benefits; and 2) careful instructions to, and observations of, the individual patients are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

Indications: Symptomatic relief of adult rheumatoid and degenerative joint disease unresponsive to adequate trial of salicylates and other measures of established value, such as appropriate rest. Has been found effective in active stages of: 1) moderate to severe rheumatoid arthritis including acute flares of chronic disease, 2) moderate to severe rheumatoid (ankylosing) spondylitis, and 3) moderate to severe degenerative joint disease of the hip (osteoarthritis of the hip). Has been found effective in relieving pain and reducing fever, swelling, and tenderness in acute gouty arthritis in selected patients. May enable reduction of steroid dosage in patients receiving steroids for the more severe forms of rheumatoid arthritis; in such instances the steroid dosage should be reduced slowly and the patients followed very closely for any possible adverse effects.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin and indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.
Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.
Central Nervous System Effects: INDOCIN (Indomethacin, MSD) may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis, which may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.
Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.
Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.
Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.
Hypersensitivity Reactions: Acute respiratory distress, including dyspnea and asthma; angiitis; pruritus; urticaria; angioedema; skin rashes.
Ear Reactions: Hearing disturbances, deafness, tinnitus.
Central Nervous System Reactions: Psychotic episodes, depersonalization, depression, coma, convulsions, peripheral neuropathy, drowsiness, mental confusion, lightheadedness, dizziness, headache.
Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.
Dermatologic Reactions: Loss of hair, erythema nodosum.
Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

Supplied: Capsules containing 25 mg indomethacin each, in bottles of 100 and 1000; capsules containing 50 mg indomethacin each, in bottles of 100.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

MSD **MERCK SHARP & DOHME** | **where today's theory is tomorrow's therapy**
Division of Merck & Co. Inc West Point Pa 19486

(Continued from Page 821)

Since they do not need this investigation in order to be a member clinic, don't get any fancy certificate, and don't get any increase in the fees they can charge, you may wonder why they bother. The answer is that any group which wishes to improve, and I have never seen one yet that was close to perfection, can only benefit from a critical review by informed fellow physicians. So far, each group reviewed has thought that it was more than worth the effort and expense.

You might also ask why a doctor would leave his practice for a couple of days to go prowl through another clinic. The answer here involves more than altruism. It is impossible for an intelligent man to spend 2 days watching other doctors practice medicine without learning something which will be to his benefit. Remember you never had a medical school course in how to run an office. Whether you are in group or solo practice, it is doubtful that you are so efficient that you could not learn even better ways, either by having another doctor visit you or by your spending time observing his practice.

So the purpose then is not just to save taxpayers money, not just to assure the public of quality and effectiveness but also a form of continuing medical education for both the reviewer and the reviewed.

The next problem we face then is what is it we should review? It seems obvious from the past discussion, we must review all there is of medical care, at least, and very possibly in the future, all there is in health care. Certainly we must review the medical treatment given in hospitals and extended care facilities. More recently it has become increasingly obvious that, like it or not, we must also review the medical care given in the office. It may be difficult, but it is certainly essential.

Next, you might ask, what are we looking for? First, of course, is fraud which in medicine is no different from any other kind of fraud and the duty of the peer review team is no different than that of any other honest citizen. Fortunately, this is rare and soon taken out of the hands of the physicians. The next item for which we look, of course, is the too high fee, something we have done traditionally for many years. Beyond that, we must now begin to look at utilization—that is the number of services rendered and even beyond that to the efficiency and quality of care rendered. It is no longer enough to tell people that they have not been cheated or just that the fee for a given service is not too high. They need assurance that they are receiving a good quality of care for the money they spend.

Techniques For Meaningful Review

The last question is probably the hardest. Once we have decided that review is necessary, what techniques can we use to make this review truly meaningful? How do we do it? The traditional technique for peer review has been the use of a Grievance Committee or Insurance Review Committee which simply look at those physicians about whom there has been a complaint—usually already known to all the doctors in the area. But, what we're speaking of now goes well beyond this system. In a number of parts of the country it has been possible, particularly under the government programs, but not only under them, to do a form of total claims review by computer. This will give a gross review of a man's practice. From this can be developed a number of statistics: the number of visits per day; the number of visits per patient; the number of visits per diagnosis; the number of shots given per visit; the number of lab x-ray tests per visit; and from this, one may obtain an over-all view of a physician's practice. Dr. Donald Harrington of the San Joaquin County Foundation has done a great deal of work on this, initially only on private insurance company contracts, later on Medicaid as well, and has been able to set up perameters of electronic observation which have enabled him to spot "deviant practitioners." Those doctors who have an unusual number of injections per patient visit

in the office or others who never seem to be able to see a patient without doing a urinalysis or blood count, those who must see a patient 2 or 3 times a week for a rather routine diagnosis such as osteoarthritis, etc. Doctor Harrington would be the first to tell you that you can not leap to conclusions simply from a computer analysis.

There are all sorts of reasons for variations from the norm in practice. The mere fact that a man practices in a different way is no proof at all that he is a "bad" practitioner. In this country, and particularly in medicine, uniformity and conformity are not necessarily the ideal.

There are other reasons for the inherent errors in the computer method including local variations, particularly the differences in style of practice between rural and urban doctors and of the disadvantaged areas versus the middle class suburbs.

The next step must always be to pull out the original claims forms for review. Here one can look over the number of tests ordered and paid for on the basis of the diagnosis and also the amount of treatment and its relevance to the diagnosis placed upon the claims form. Once the peer review committee has gone through the computer analyses, selected from it those claims forms it needs for review, and then reviewed these forms from unusual practitioners, it still has not established the fact that the doctor involved practiced a poor quality of care.

Let me give you an example. In my former county, Santa Clara, we have a moderate size city, San Jose, with some 400,000 citizens. The city is split by Highway 101. On the West side of the highway are the English speaking citizens, generally from the lower middle class on up. On the East side of the highway are the Spanish speaking citizens, usually of lower income groups. In reviewing claims under our Medicaid program, which review is done by the County Medical Society, we found the Spanish speaking doctors East of the highway invariably gave penicillin injections to children with a cold. We Anglos, of course, were certain we had spotted an obvious abuse of the program. A group of men who were committing malpractice simply in order to collect extra funds for giving shots under the program. A committee of righteous, outraged county society members descended upon our Spanish speaking confreres in order to bring the wayward brothers back into the fold. Well, the message was delivered alright, but it was we who got the message.

It appears that in this type of community, among the lower income Mexican-Americans, faith in physicians is erratic and on a semi-mystical basis. The doctor is given one chance at the illness. When the baby has a cold, he and the rest of the family are bundled up and brought into the doctor. Whatever the doctor does is fine with the mother, but no matter how much sicker the child gets afterward, he will not be brought back since there is not any reason to. "He's already seen the doctor." Further remedies are likely to include prayer or forms of folk medicine. Furthermore, the mothers have very little faith in pieces of paper or long explanations. Telling the mother that she should take a prescription and fill it at a drug store and then to give pills to the child if he should get sicker, simply results in another piece of scrap paper in the waste basket by the front door of the doctor's office. Even giving samples of pills to be taken later is no assurance that the child will receive any further treatment. Therefore, if there is any possibility that the baby may develop bacterial bronchitis or pneumonia from the cold, the only assurance that he will survive is for the physician to actually place the penicillin into the child himself.

While we may all hope that in the future education and an elevation of income level will change this situation, for the present it continues to be malpractice or at the very least poor medical practice to give penicillin for colds in the English western half of the city while it is malpractice not to do so East of the highway.

There are many other examples all of which add up to mean that the review of quality can only be done locally, it can only be done by people who can understand the variations and circumstances, which in the end means that it can only be done by other local physicians. It must be done by physicians, because lawyers, for instance, are so bound by technicalities that common sense or what is best for the people rarely enters their minds and to allow them control of the program would be disastrous.

For example, in one of our large cities in California, it became evident after a period of review that of 8 minority doctors in one area, 6 were abusing the programs through over utilization. Too many injections per patient visit, too many laboratory tests, etc. This assumption was reinforced by visits to their offices and therefore the county medical society recommended that they no longer be paid under the Medicaid program. The first two telephone calls to the medical society were from the other two minority physicians—the "good" doctors in the area. They were terribly unhappy. "Are you trying to kill us? There are too many Medicaid patients already for the 8 of us. Two of us even working 24 hours a day couldn't possibly handle the load, and we certainly couldn't give any quality of medical care. You must keep the other 6 doctors working for the good of the people of our part of the city."

The Medical Society was understandably reluctant, but it also was understanding of the problem on the basis that even over-utilized medical care is better than none at all. Those doctors were reinstated in the program, although the County Medical Society has since attempted a practice educational process for them. Again, what this adds up to is that there must be local control of the program, there must be local understanding of local problems and there must be an interest on the part of physicians of the Medical Society in seeing that medical care is given to the people.

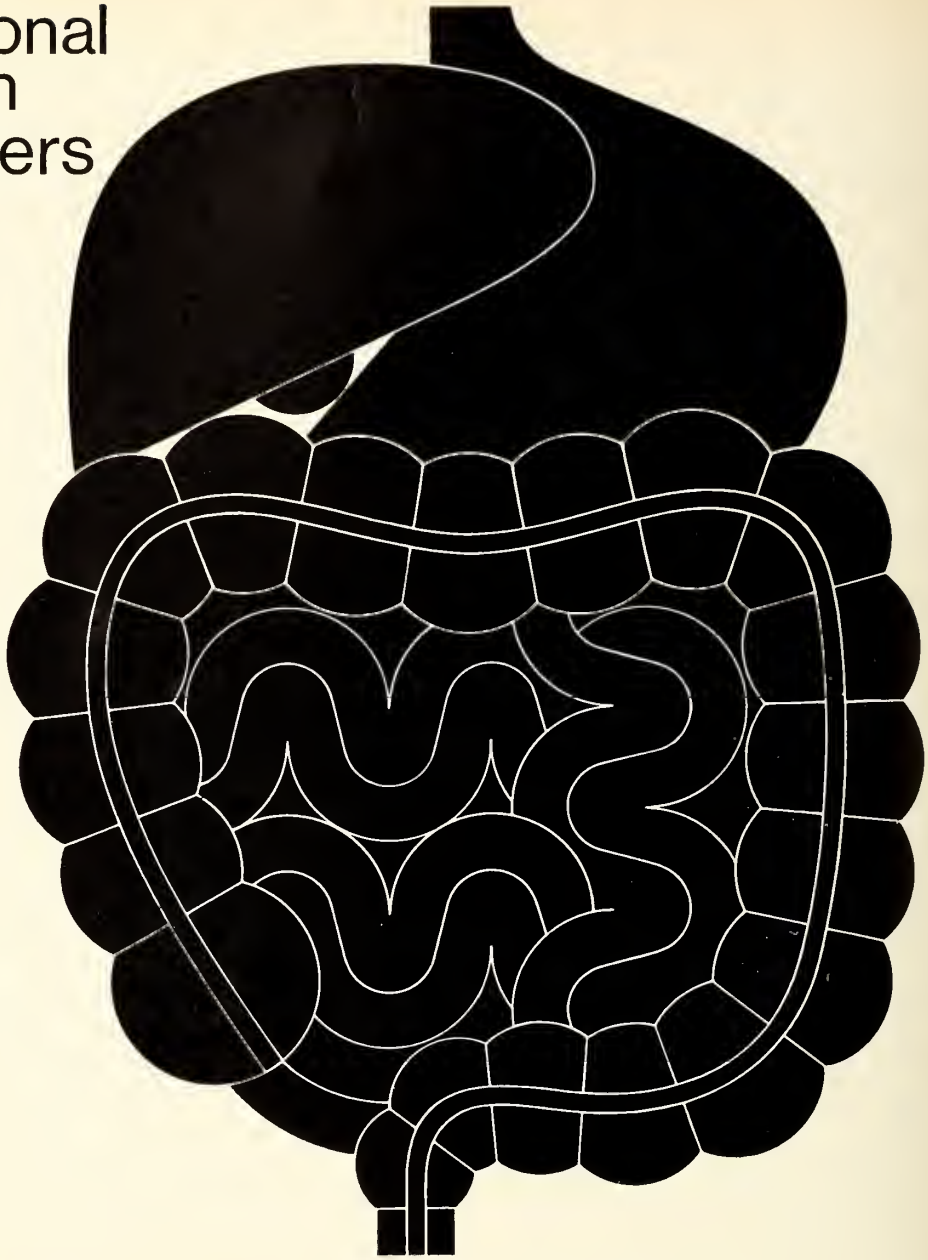
Let me make a summary about the benefits to be derived from this program. I have mentioned the direct benefits, of course, to the taxpayer, to the reviewing physician and to the physician who is reviewed, but there are other benefits, one of these comes from publicity. It is no secret that the medical profession has a "bad image." The knowledge that the doctors in the County Medical Society are spending hours reviewing the quality of care can only do good things for us. In the past, as you know, we have only allowed publication of bad publicity about doctors, so it is not surprising that we have a poor image. In the past, if the doctor did something good for a patient, we have forbidden this news to be printed because we felt it amounted to advertising. However, if something bad happened—a drunk driving conviction or malpractice suit—nothing the Medical Society could do would ever keep the news out of the paper. For this reason, our patients have read only unfavorable things about doctors and naturally formed that kind of an opinion. I might suggest as an aside to the principle subject that we may have to reconsider our entire concept of physician publicity. However, whether we need to change our attitude toward publicity or not, there can be no doubt about our need for peer review.

The People of this country deserve to know their medical care is all it should be. The best guarantee of this can be given only by the concerned physicians of an area working together in an effective program of Peer Review.

1. Congress demands it;
2. Our patients deserve it; and
3. We need it.

---

for nutritional support in G.I.disorders



Berocca®

TABLETS
high potency B-complex and C for nutritional support

AVAILABLE ONLY ON Rx

contains water-soluble vitamins only

b.i.d. dosage provides full therapeutic amounts

good patient acceptance

no odor, and virtually no aftertaste

Each Berocca Tablet contains:

Thiamine mononitrate	15 mg
Riboflavin	15 mg
Pyridoxine HCl	5 mg
Niacinamide	100 mg
Calcium pantothenate	20 mg
Cyanocobalamin	5 mcg
Folic acid	0.5 mg
Ascorbic acid	500 mg

Usual dosage is one tablet b.i.d.

Indications: Nutritional supplementation in conditions in which water-soluble vitamins are required prophylactically or therapeutically.

Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B_{12}.

Dosage: 1 or 2 tablets daily, as indicated by clinical need.

Available: In bottles of 100.

ROCHE

Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

majorcan carnival

MASA Journal To 'Cover' Popular Mediterranean Vacation

A big jet of the Overseas National Airways will roar off the runways of Birmingham's Airport on Saturday morning, June 13th, carrying a plane load of Alabama doctors, their wives and children across the Atlantic for a memorable week on Majorca, queen of the Balearic Islands, in the Mediterranean.

With reservations already running far ahead of any previous cruise of the Medical Association members, the Majorcan Carnival promises to be the most popular of any, with its added offering of side trips to Madrid and to Algiers, on the African coast.

Palma, a city the size of Montgomery, is the capital of this beautiful, historic island, located just 135 miles south of Barcelona. Its recorded history began with the Romans, followed by the Vandals, the Arabs, the Moors and latterly by European Christians, each civilization contributing something to its artistic charm. It is a city combining the old and the modern, with such tourist attractions as the 13th-century cathedral built on the site of a Moslem mosque, and 14th-century Bellver Castle, a stronghold overlooking the town and bay, that houses the spectacular Municipal Museum.

Price of the round trip, including transportation, tips, breakfasts and dinners, and other features is $349 plus $19.50 tax and services. This is for double occupancy. Optional side trips, to continental Africa and to Madrid, are $40 each, and are scheduled on different days so that participants in the Majorcan Carnival may take both trips if they wish.

As an innovation for this trip, the week's vacation in the Mediterranean will be "covered" by experienced newspaper people with stories and pictures to appear in subsequent editions of the Journal of the Medical Association of the State of Alabama.

While no limitation has been put on spaces available for the Majorcan Carnival, those desiring to go should fill in the attached coupon, and mail it in promptly with a $50 deposit for each member of the party.

MASA-MC3
6-13-70

THE MEDICAL ASSN. OF THE STATE OF ALABAMA
19 S. Jackson Street
Montgomery, Alabama 36104
(205) 263-6441

Gentlemen:
Please find enclosed $_____ as deposit ☐ as full payment ☐ for _____ NO. OF PEOPLE
Make check or money order payable to: MAJORCAN CARNIVAL
$50 minimum deposit per person. Final payment due 30 days before departure.

NAME _____ PHONE _____
PLEASE PRINT NAMES OF ALL PASSENGERS
STREET _____
CITY _____ STATE _____ ZIP _____
DEPARTURE DATE _____ DEPARTURE CITY _____

Return this reservation immediately to insure space. Reservations limited. Rates based on double occupancy. Single rates $50 additional. AITS reserves the right wherever necessary to substitute comparable hotel accommodations and plane equipment.

OPTIONS

Please check the option(s) you desire.
☐ Continental Africa Option $40.00
☐ Madrid Option $40.00


Each 5 cc. contain erythromycin estolate equivalent to 250 mg. erythromycin base.
PINT (473 cc.) M-148
Lilly
ILOSONE
LIQUID
ERYTHROMYCIN ESTOLATE
ORAL SUSPENSION, U.S.P.
125
SHAKE WELL BEFORE USING
REFRIGERATE
AVOID FREEZING
PINT (473 cc.) M-153
Lilly
ILOSONE
LIQUID
ERYTHROMYCIN ESTOLATE
ORAL SUSPENSION, U.S.P.
250
SHAKE WELL BEFORE USING
REFRIGERATE
AVOID FREEZING
When mixed as directed, each 5 cc. will contain erythromycin estolate equivalent to 125 mg. erythromycin base.
When mixed as directed, each cc. will contain erythromycin estolate equivalent to 100 mg. erythromycin base.
Each 5 cc. contain erythromycin estolate equivalent to 125 mg. erythromycin base.
Lilly
ILOSONE
CHEWABLE
125 mg.
Each tablet contains erythromycin estolate equivalent to 125 mg. erythromycin base.
100 PULVULES® No. 375
Lilly
ILOSONE
ERYTHROMYCIN ESTOLATE
CAPSULES, N.F.
250 mg.
100 PULVULES® No. 374
Lilly
ILOSONE
ERYTHROMYCIN ESTOLATE
CAPSULES, N.F.
125 mg.
Each Pulvule® contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule contains erythromycin estolate equivalent to 250 mg. erythromycin base.
The many forms of Ilosone®
Erythromycin Estolate
Lilly
Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206
900761

THE JOURNAL

of

THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

Published Under the Auspices of the Board of Censors

Volume 39 March, 1970 No. 9

Pylephlebitis And Liver Abscesses Following Appendicitis

Harry J. Till, M. D., John M. Cameron, M. D.
and Robert L. Dorrough, M. D.

Suppurative thrombosis of the portal vein (pylephlebitis) following appendicitis is rare in our practice. We have been aware of its existence since medical school days but had ceased to fear it as a serious complication of appendicitis. The following fatal case reminds us that it remains an ominous threat.

Case Report

A 75 year old white male was admitted to St. Margarets Hospital, Montgomery, Alabama, on 3-16-67, through the Emergency Room with rather classical symptoms of acute appendicitis. He was referred to us by Drs. John Wade and John Yow, who managed the medical aspects of the case. He had a 24 hour history of nausea, anorexia and periumbilical pain, which migrated and localized in the right lower quadrant. There was tenderness at McBurney's point. There had been no previous episodes. He was known to have diabetes controlled by oral medications and an asymptomatic aortic aneurysm. His iliac and popliteal arteries were good. There were no pedal pulses on the right but good pulses on the left.

From the Department of Surgery, St. Margarets Hospital, Montgomery, Alabama 36104

On admission his fasting blood sugar was 220 mgm% and his urine was 3+ positive for sugar. The BUN was 15 mgm%. His white blood count revealed 6,413 wbc, 74 segs, 21 lymphs, 2 monos, 2 stabs, and 1 eosinophil.

On the day of admission an appendectomy was performed for an acute gangrenous nonruptured appendicitis. There was a little turbid fluid in the right lower quadrant of the abdomen but no free pus was present. The appendix was easily delivered and removed using 0 chromic for the meso ties and 2-0 chromic for inverting the stump. He had no Meckel's diverticulum. A hand exploration of the abdomen was done and a five inch fusiform abdominal aortic aneurysm below the renal arteries was noted. His external and internal iliac arteries were soft and pulsated well. The stomach seemed normal. The gallbladder was obliterated, probably by disease. The incision was closed with chromic gut and the skin with nylon.

For two days following surgery the patient did well. The temperature was 99.6. No antibiotics were given. At 5:30 p. m. on 3-19-67 his temperature spiked to 102. He became acutely ill with chills, fever, prostration, vomiting, rapid pulse and rapid respiration. This continued and blood culture was

done. His blood sugar was 300 mgm%, his urine 4+ for sugar. The diabetes was controlled with insulin. On 3-22-67 gram positive cocci were found in the blood culture. Beta hemolytic streptococci were later identified. He was given Kantrex and Chloromycetin until the blood cultures were returned, at which time he was put on 20 million units of penicillin intravenously, daily for three days.

Clinically the patient continued to spike fever to 102 and 103 and remained on a definite downhill course. This was essentially the picture of severe febrile postoperative course without localizing signs. We had opened the wound previously on 3-21-67 down to the peritoneum and no pus was present. Examination of the abdomen during this time was not remarkable, except for that expected postoperatively for rather severe appendicitis. A liver photoscan was done which revealed a slight defect in the right lobe posteriorly on the lateral film. The stools were tarry on 3-27-67.

On 3-28-67 laparotomy was performed using a right subcostal incision. We had suspected subhepatic space abscess around the liver. The general lower abdominal cavity was essentially clean. There was no generalized peritonitis or pus collection around the appendix or cecal area. There were no subphrenic or subhepatic abscesses. The right lobe of the liver felt firm and rounded. We aspirated this with a long No. 18 needle in several places and located a pus pocket consisting of about 30 cc of thick, brown, foul pus. We aspirated about 10 cc of pus from the right lobe near the gallbladder bed. Multiple areas were aspirated but only one or two other small sites contained pus, the others were negative. The gallbladder was contracted and more or less obliterated. There was no acute cholecystitis. The pancreas felt all right. We did a gastrostomy and found no blood in the stomach. The wound was drained.

Cultures from the abscess revealed E coli. Unfortunately the anaerobic cultures were not done due to a misunderstanding in the laboratory. The patient improved clinically for several days following this and was eating. However, he continued to have fever. He was given Coly-Mycin but continued on a downhill course.

On 4-2-67 he started massive hematemesis and melena and losing blood through the gastrostomy tube. Continued bleeding necessitated another operation. On that day we did a midline laparotomy and found multiple superficial gastric ulcers. We sutured some of these and did a vagotomy and pyloroplasty. Repeat liver puncture was negative this time. Again there was no pus collection in the abdomen. A feeding tube was placed in the upper portion of the jejunum and gastrostomy tubes were placed. At this time it was noted that the patient bled a good bit from the incision. His porta hepatis was thickened, being definitely abnormal, but we did not diagnose portal occlusion at this time. The patient continued on a downhill course with multiple terminal complications. He had bronchopneumonia, bled again, had a wound separation of the lower portion of the laparotomy, and expired on 4-12-67.

At autopsy the liver weighed 2300 grams. The portal vein was thrombosed. The thrombus appeared to be recent. There was purulent material partially filling the portal vein and all its radicals. There were multiple abscesses in the liver, parenchyma, most marked on the right side. The largest abscess was 5 cm in diameter. The gallbladder was obliterated, the common bile duct slightly dilated. The aneurysm was noted and was unruptured.

Discussion

Pyogenic liver abscesses are rare and many probably heal without a diagnosis. The infection may enter the liver from one of several avenues:

1. The biliary tract, after common duct surgery or suppurative common duct disease.

2. Via the hepatic artery in cases of septicemia and bacteremia.

3. From inflammation within the peritoneal cavity as in appendicitis and diverticulitis via the portal vein. Our case is an example of this type of entry.

Amebic and solitary abscesses of unknown origin, or cryptogenic liver abscesses may also occur.[1] Liver abscess should be suspected along with subphrenic abscess in cases of prostrating febrile course, with chills and fever, without localizing signs. A liver photoscan will usually help confirm the liver as the site of the abscess and inflammation. We commonly suspect subhepatic abscesses in cases of unexplained chills and fever, but we should include a high index of suspicion of liver abscesses and get a scan of the liver in these cases.

Treatment

The treatment of solitary liver abscesses is adequate surgical drainage by open drainage or aspiration and appropriate antibiotics. Foul, putrid pus usually indicates anaerobic organisms. Anaerobic as well as aerobic cultures should be made in all cases. In cases of anaerobic streptococci, penicillin G in large doses is the drug of choice.[2] The antibiotic of choice will be indicated by sensitivity studies in other pyogenic liver abscesses. In cases of suppurative thrombosis of the portal vein with multiple small liver abscesses the treatment is much more difficult, as indicated in our case. In diffuse involvement adequate drainage is impossible. Some sort of venous shunt, for example, splenorenal, could have been considered at the second operation for the portal hypertension which caused various bleeding problems. However, the treatment for this condition remains antibiotics, supportive therapy and aspiration of the larger abscesses.

We do not routinely use antibiotics after acute unruptured appendicitis. One wonders if antibiotics would have prevented this complication.

The above case, added to our existing cases of serious and sometimes fatal complications of appendicitis, causes us to worry less about occasionally removing a normal appendix, and encourages us to continue to remove the appendix when in its vicinity in the abdomen and no contraindication exists.

Summary

We have reported the only case of suppurative pylephlebitis and multiple pyogenic liver abscesses following appendicitis that we have encountered in seventeen years of active surgical practice, during which period of time we have performed approximately 600 appendectomies. Its stormy course and fatal outcome remind us that the condition still exists as a serious complication of appendicitis.

GENERIC AND TRADE NAMES
DRUGS

Chloramphenicol	Chloromycetin
Kanamycin	Kantrex
Sodium Colistimethate	Coly-Mycin

References

1. Dorrough, Robert L.: Amebic Liver Abscess. So. Med. J. 60:305-310, (March) 1967.

2. Patterson, D., Ozeran, R., Glantz G., Miller, A., Finegold, S.: Pyogenic Liver Abscess Due to Microaerophilic Streptococci, Ann. of Sur. 362-376, 1967.

Pulmonary Function Testing For The General Hospital and Physician

D. S. Tysinger, Jr., M. D.
Dothan, Alabama

Part IV—Vital Capacity and Its Subdivisions

The vital capacity is that quantity of air which can be exchanged by the lungs from maximum inspiration to maximum expiration or from maximum expiration to maximum inspiration. It may be measured either way. It may be done slowly and leisurely or it may be done in a rapid manner such as exhaling all the air that it is possible to exhale as rapidly as possible. This latter vital capacity is known as a forced vital capacity and is the one commonly measured in pulmonary function testing. In Diagram 12, A is a slow vital capacity in which force was not necessarily used. B is a forced vital capacity (FVC) done as fast as possible. C is an inspiratory vital capacity in which the air is taken in either slow or fast but as deeply as possible. The idea with A and C is to find out simply the total amount that can be exchanged either way. However, B, or the forced vital capacity, is one in which the individual breathes out as rapidly as possible, pushing out as much air as possible. The forced vital capacity is done in relation to time. The slow vital capacity would not tell anything about obstructive disease because there is no relation to time. On the inspiratory vital capacity, since the tubes are dilating and elongating, it can be done much more rapidly than can the forced expiratory vital capacity and therefore, does not tell as much about the lung process as does the forced expiratory vital capacity (FVC). The third form of vital capacity is the combined vital capacity, as at D. From normal breathing an expiratory reserve volume is done first. Then an inspiratory capacity is done and the two added together, thereby getting a vital capacity. There are, therefore, actually four ways to do a vital capacity in an individual. In the normal individual, all four should come up with essentially the same vital capacity volume.

The first thing to discuss in using the vital capacity to diagnose diesease is trapping which is represented in Diagram 13. Trapping is related to force and to the build-up of pressure within the chest cage. In the individual who has a good bit of trapping, if first we do a slow vital capacity, he would not trap much and would get almost all the air out. Therefore, in this individual, a slow vital capacity should be larger than the forced vital capacity during which he is trapping air, as at A. Also noticed in such a patient with a slow vital capacity, and with trapping, is the fact that when the patient goes back to normal breathing he will go up to a higher level and then come back to his normal base line. If this same individual does a forced vital capacity, he will trap more; he is not able to get out as much volume. Therefore, as will be noticed at B, the forced vital capacity is smaller in volume than the slow vital capacity. Also, the signs of increasing trapping, as seen by the elevation and slow return to the normal base line are greater with the forced vital capacity. Where trapping is present, if a combined vital capacity is done, one does the expiratory reserve volume first by instructing the patient, after a normal inspiration, to blow out all he can and then go back to normal breathing. As he does there is still the elevation with return to the base line following this effort if there is any degree of trapping. When he has reached the base line again he is asked to do an inspiratory capacity and then go back to normal breathing. Here again, if there is trapping present, then there is a slow return to the base line. When the vital capacities are compared then the combined vital capacity and slow vital capa-

This is Part IV in a series of seven articles.

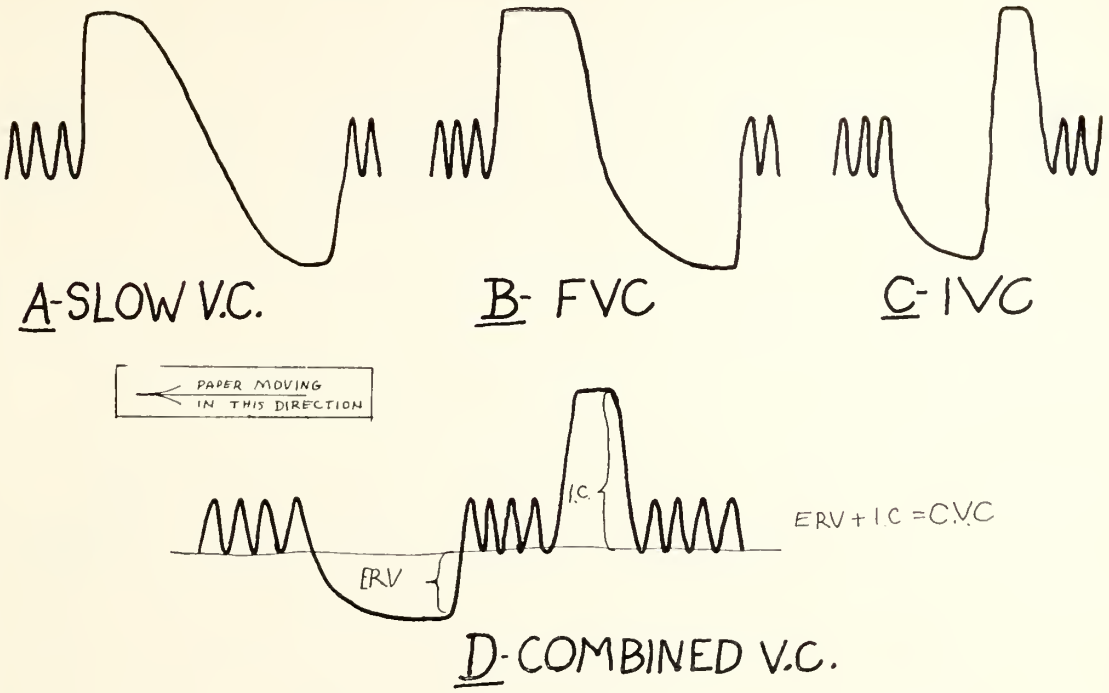


Diagram 12

city will be essentially the same but the forced vital capacity will be smaller and the degree smaller is an indication of the degree of trapping. This is an evaluation of the obstructive element that is present in certain diseases. In this situation, it is important that the vital capacity, combined vital capacity in particular, be done without the individual breathing around the mouthpiece which will change his base line. An unusually large combined vital capacity compared to the slow or forced vital capacity indicates an increase of volume other than that present in the lung-spirometer combination. The other type of vital capacity in relation to trapping is the inspiratory vital capacity as illustrated at D in Diagram 13. In this situation the inspiratory vital capacity occurring during the period when the bronchial tubes are getting larger, wider, and with less resistance usually will represent the maximum degree of vital capacity for the individual. Therefore, in evaluating trapping we can add up the combined vital capacity and compare it with the inspiratory vital capacity and the slow vital capacity. All of these should be about the same. The spirogram is checked to make sure that the effects of trapping have been reverted to normal by attaining the same base line before continuing the next procedure. The three vital capacities should be about the same and greater in amount than the forced vital capacity. There is one other routine in relation to the vital capacity which is used to indicate trapping. This is the performing of three or four successive vital capacities as rapidly as possible. Here, the individual is instructed to do a vital capacity, blowing out all he possibly can before doing the next one, and not to breathe in between. We find that each successive vital capacity gets smaller, as in E. Thus, in the process of evaluating trapping we have, just by looking at the tracing, many ways of evaluating trapping and getting a good idea of the degree of trapping that is occurring. If trapping is due to spasms, secretions, etc., that can be corrected by treatment; follow-up tracings should show improvement in these components as the patient is treated with medications.

In Diagram 14 is represented restrictive disease. The restrictive diseases that occur

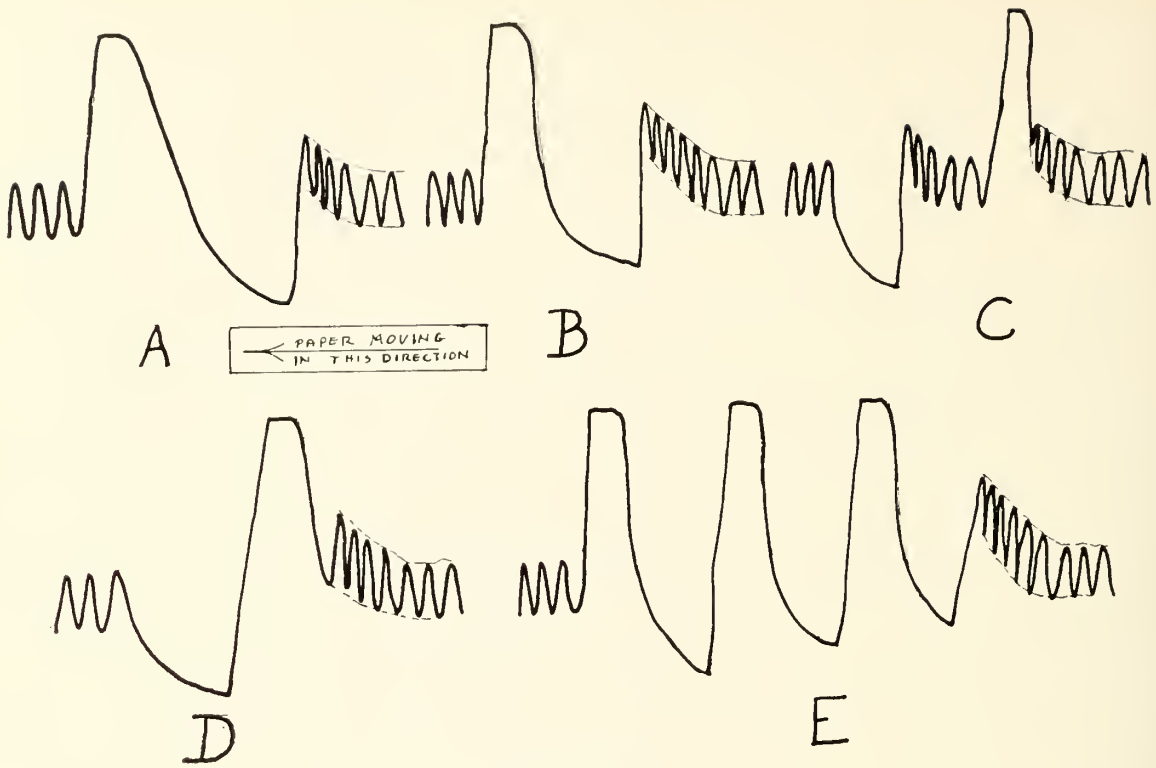


Diagram 13

may effect neither the timed segments of the forced vital capacity nor any of the other forms of measuring the vital capacity. The curve will be essentially normal with the exception that the volume will be small. Before describing diagrammatic representation of restrictive processes, it might be well to speak a moment about spirometers. Unlike electrocardiography, in which all machines have basic standardizations so that electrocardiograms are comparable, different breathing machines have different curves, depending on the speed of the drum on which tracings are recorded and also depending on the volume of the bell in which volume exchange occurs. The smaller the volume of the bell, the greater the travel of the bell will be per cc. of air breathed. Therefore, it is very important for the person interpreting pulmonary function tests to become familiar with his own equipment so that evaluation of the normal curve is familiar as is subsequent evaluation of abnormal curves. In Figure 14 is represented a forced vital capacity in the normal at A and a forced vital capacity at B which is normal in relation to total capacity of this individual, but is reduced in comparison with A or the normal. On expiration, as the vital capacity is first started, the back is straightened, the head and shoulders are thrown back, and the abdomen is maximally distended to get the diaphragm down so that the maximum volume of air can be taken into the lungs. Then, on the instruction "go" as the patient starts to breathe out, there is a lapse of time between the time that the elastic structures start to work and the muscular factors come into play. So, instead of a sharp right angle decline in the tracing from the straight line as written on the paper, there is a slight bend. As muscle factors catch up with the elastic forces, then there is a rapid egress of air with an almost straight line being traced until the tidal volume range is reached. At this point the muscular effort to further contract and expel air begins to be quite a problem so that at this point there begins a slope of the curve back to the flat line. This is the way a normal vital capacity slope develops due to these factors that come into play in doing the forced vital capacity. This makes it neces-

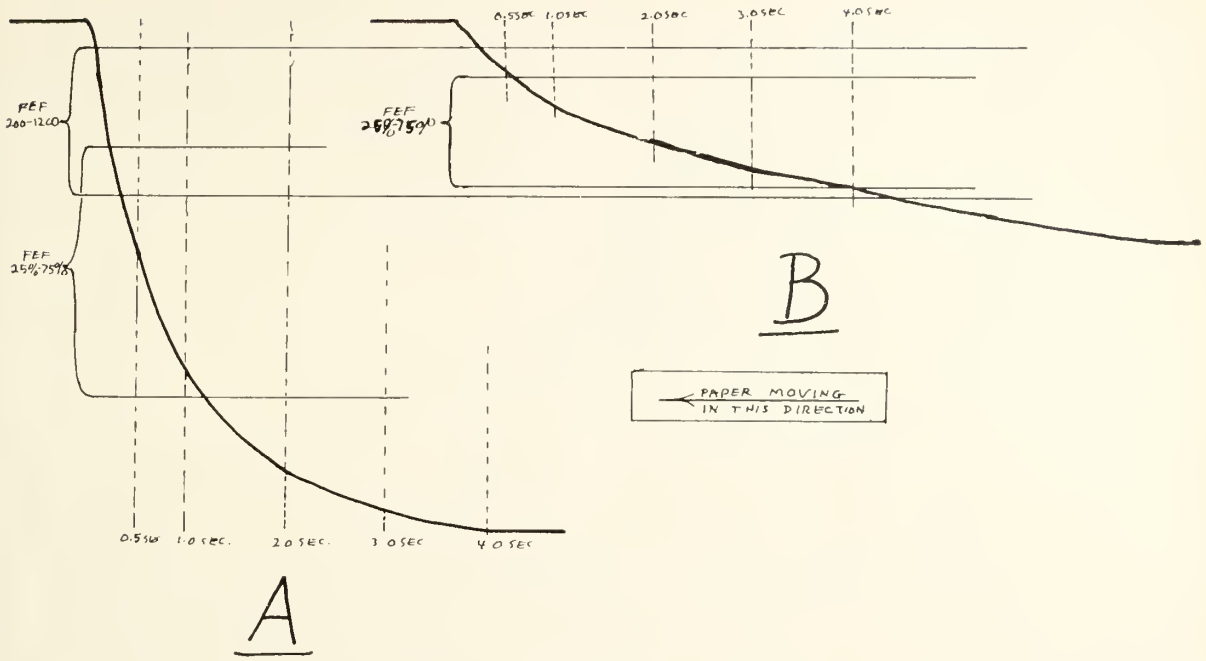


Diagram 14

sary to evaluate various portions of the vital capacity as it is done, those usually measured are the half-second, one-second, two-second, and three-second forced vital capacity in an effort to evaluate the effectiveness of function at these various times. This is known as forced expiratory volume or FEV expressed as 0.5, 1, 2, or 3; an example being FEV 0.5. The half-second vital capacity is done at still a higher level of inspiration and should include 50 per cent of the total vital capacity. The one second should indicate 70 to 75 per cent of the vital capacity as already expelled. This is referring to each as per cent of the total vital capacity. Now to look at the purely restrictive patient, at B, the volume is reduced to less than 80 per cent of what it normally should be. If the timed fractions are evaluated in relation to the total, then the half-second is 50 per cent or better, the one second is 75 per cent or better, the two second is 90 per cent or better, the three second is 95 per cent or better, and by four seconds the total vital capacity is completed. Therefore, everything in relation to the vital capacity other than total volume is within normal limits. The total vital capacity, in relation to predicted or normal total vital capacity is small. Therefore, there is purely a restriction of total volume and this is restrictive disease. In this situation, a slow vital capacity, an inspiratory vital capacity, and a combined vital capacity, are equally reduced and without signs of trapping.

Next is Diagram 15. In this situation there is a C factor disease, obstructive disease, in the airways. As this individual breathes in, his bronchial tubes are getting larger, longer, with an increase in collapsing forces. However, with A as a normal comparison, as one starts to breathe out in a forced vital capacity the initial flow is quite rapid due to the large size of the tubes and the force developed. However, as the one-half, one, two, and three second timed segments are reached each is progressively worse than predicted. Compared with the normal, the half-second is nearer normal for this total vital capacity than the one second. The one second is nearer normal than the two; the two is nearer normal than the three. Each gets progressively worse because, as the air is expelled, the bronchial tubes get smaller, turbulence is developed, resistance is in-

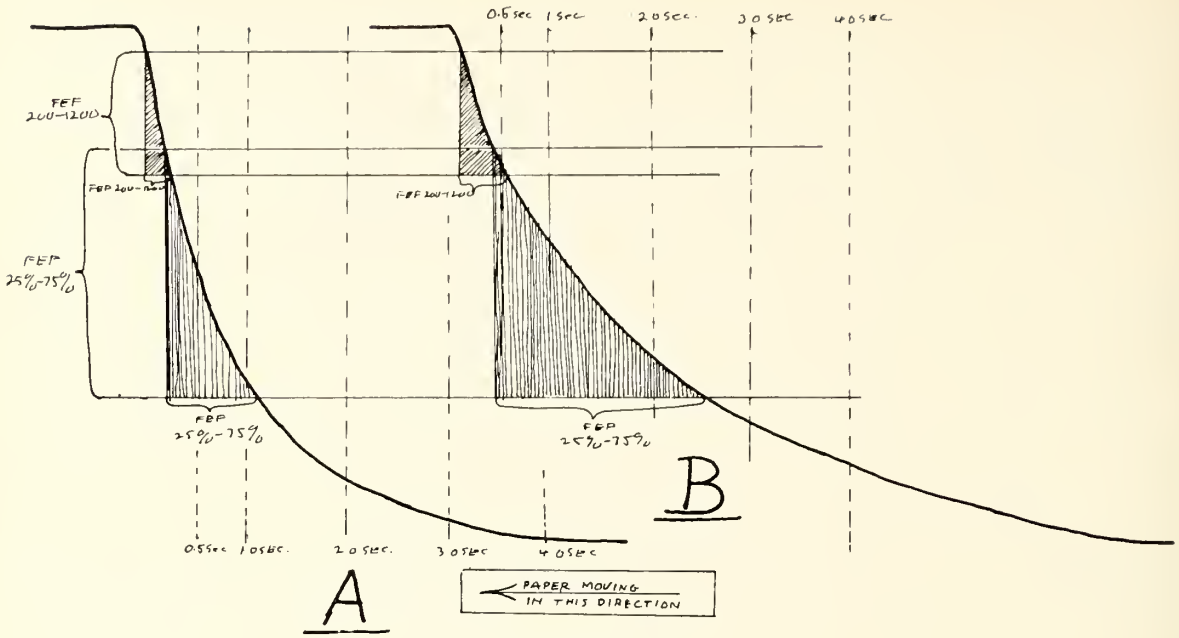


Diagram 15

creased, and it takes longer and longer to expel air. In obstructive disease, though the elasticity is still good and the force is still available, there is progressive slowing of the vital capacity curve due to obstruction along the airway and it may take up to two or three times normal to completely expel the vital capacity. In this situation of a single obstructive process the vital capacity may be normal or near normal in volume, the per cent less than normal giving an idea of the severity of the process. With obstructive disease plus trapping, one may get also significant reduction in volume. In such an instance, there is both restrictive and obstructive disease present, the restrictive disease being obviously secondary to obstruction and trapping. As pressure is developed in doing the vital capacity, turbulence and obstruction may combine to cause cessation of air flow. At this point we find a force applied to the gas, and according to Pascal's law, this pressure is equally distributed throughout the remaining volume. At this point Boyl's law, Graham's law of diffusion and Fick's law of diffusion come into play. If at this time pressure is continued and there is a small opening remaining then air will continue to move out very slowly by diffusion. Therefore, in doing a forced vital capacity, trapping may not always show up if a sufficient amount of time to empty the lungs is taken. If however, there is bronchiolar collapse in front of the trapped area, then it is unlikely that this area will reopen because the pressure being maintained will continue bronchiolar collapse and in this instance trapping will remain and will reduce the volume of the vital capacity.

When there is loss of elasticity, as in emphysema, the initial one-half to one second vital capacities, which usually have large volumes secondary to normal pulmonary elasticity, are diminished and instead there is the slow, almost flat vital capacity curve as demonstrated in Diagram 16 B. Here, at A, is represented a normal curve with a normal one-half, one, two, and three second vital capacity. Then, there is the emphysematous curve with the loss of elasticity which shows a markedly reduced one-half, one, two, and three second vital capacity. Even though all are greatly reduced the one-half and one second capacities are more reduced in relation to total than are the two and three second capacities, this being indicative of elastic tissue loss and disease of the emphysematous type. In this situation, all the collapsing of the lung that is done must be done by the muscular effort of the chest cage.

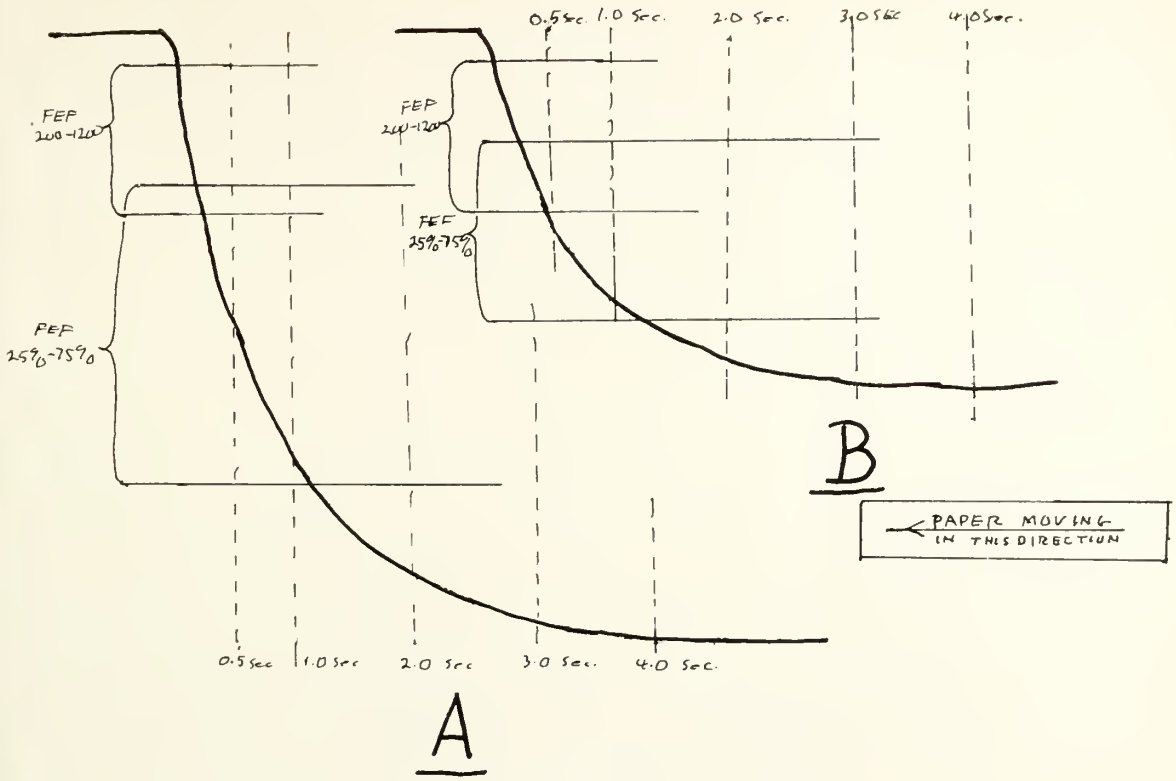


Diagram 16

The usefulness of the vital capacity in evaluating trapping, restrictive disease, obstructive disease, and loss of elasticity disease has been presented. As a rule, in evaluating pulmonary disease there are evaluated elements of restriction and obstruction and a loss of elasticity, with or without trapping. Frequently, all of these can be improved and the degree of improvement is important. As a simple guide, tests done before and after bronchial dilators may be of value. In this situation, the vital capacity is performed and evaluated both as per cent of total and also as per cent of predicted value. Both of these measures are important and should be included in evaluation. If, after a bronchial dilator, there is increase in total volume, there may be greater increase in total volume (relieving of trapped areas) than there is of the 0.5, 1, 2, and 3 second vital capacity. There may be more increase in the 1, 2, 3 second volume (relieving of obstruction) than there is in total volume increase. In comparing the 1, 2, 3 second vital capacity to the total, if the total increase is more, then if the only measured is as per cent of the total vital capacity, one gets the impression things are worse after bronchial dilators because the total volume improves more than the timed vital capacity fractions. If comparison is both with per cent of predicted and per cent of total following bronchial dilators though, they do not increase as great as the total vital capacity; they do increase in relation to the before and after so that by using both measurements one can get a good idea of how much one is relieving obstruction as opposed to how much one is reducing trapping. An individual who so responds will benefit from bronchial dilators and expectorants. It has been shown, as mentioned in previous publications, that even if there is no improvement, chances are almost 100 per cent that there will be a reduced work of breathing and increased pulmonary efficiency over the course of long-term therapy by the use of bronchial dilators and expectorants.

Not discussed are the forced expiratory flows, known as FEF. Since it takes about 200 cc. flow in the normal to get both elastic forces B, C, and D and the chest cage, A, to begin working at maximum rate, then maximum flow rates occur during the first 1 liter

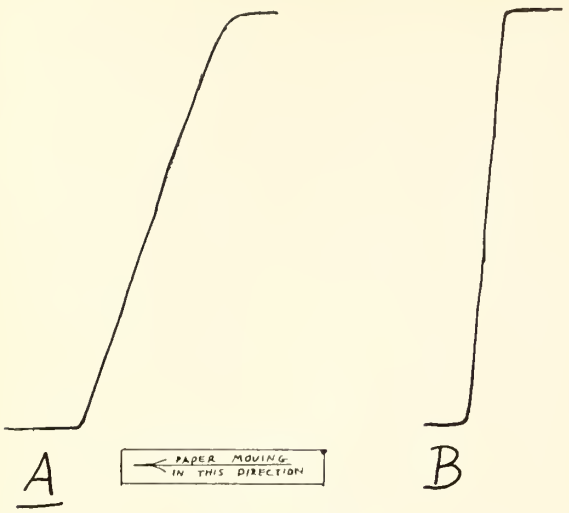


Diagram 17

after all forces begin to work. This is, therefore, measured as the FEF 200-1200 ccs. This is the fastest flow and is similar to the 0.5 FEV in evaluations. Next is the midflow or flow rate of the middle 50 per cent of the vital capacity or FEF 25-75 per cent. This is comparable with the 1 and 2 second vital capacity. Whatever effects either of these timed volumes would also effect the FEF 200-1200 and the FEF 25-75 per cent to bottom.

Finally, in evaluation of lung disease there is the differentiation of the stiff fibrotic lung which is different from the restrictive disease previously mentioned. There is secondly, the stiff lung which is seen secondary to heart failure; thirdly, there is the stiff lung which is noted secondary to increased surface tension and viscous resistance. In these three situations the inspiratory vital capacity is similar and abnormal. Inspiration is quite labored with marked B, C, and D factor resistance. This causes the forced inspiratory vital capacity to be quite flat and slow in comparison to the normal. By using the forced inspiratory vital capacity these three may be differentiated from each other. If this flat inspiratory curve (Diagram 17A) is due to congestive heart failure it can be improved by the transfer of fluid from the pulmonary circuit to the peripheral circuit by IPPB without medication other than moisture in the nebulizer. The physiology of this was discussed in "The Place of Respirators in the Coronary Care Unit", which appeared in the *Alabama State Medical Journal* in October of 1969. Therefore, following a fifteen minute period of IPPB one finds improvement in the inspiratory vital capacity towards normal (Diagram 17B). If, on the other hand, following a fifteen minute period of IPPB with just moisture there is no change, heart failure has been ruled out. This leaves a surface tension type of stiffness or just frank fibrosis as in the silicotic lung. If now a 15 minute treatment period of 20 per cent Ethinol and four drops of Racemic Epinephrine is given, if the flat inspiratory curve is due to a surface tension type problems, this will be alleviated and the curve will return towards or to normal. If after both routines the curve remains unchanged, then this is a fibrotic lung and heart failure and surface tension flow rate obstructive type problems have been ruled out. This is a simple test that can be done with pulmonary function testing and completes our discussion of the vital capacity and its various uses.

Studies done with the flow volume loop show the same three patterns, restrictive, obstructive, and loss of elasticity. Smoking cigarettes slowly begins to change the vital capacity curve. This is first noted as an increased time to expel the 50-75 per cent portion of the vital capacity. In the normal 50 per cent is expelled in 0.5 seconds and 75 per cent is expelled by one second. The first breakdown noticed in cigarette smoking is in the FEF 50-75 per cent. This occurs when there are no symptoms and everything is apparently normal.

Every smoker develops a bronchitis sooner or later which sooner or later produces an obstructive pattern and should, therefore, have a chest X-ray and vital capacity every six months to one year.

Restrictive disease may leave the FEF 200-1200 normal while reducing the FEF 25-75 per cent. Obstructive disease usually reduces the FEF 25-75 more than the FEF 200-1200. Loss of elasticity reduces both equally or may reduce the 200-1200 more than it reduces the 25-75 per cent.



Campbell's Soups... wide variety...for limited appetites

Many people lose interest in food as they grow older. Some of them are fussy eaters—with only a few favorite foods. Others become indifferent to foods—because planning and preparing meals becomes a chore. Here Campbell's Soups can help —for these four very good reasons:

Appeal With a variety of tastes, textures, aromas, and colors, Campbell's Soups can add interest and appetite appeal. And they're easy to eat—ingredients are tender, bite-size. Even patients on special diets will find soups they can enjoy among the more than 50 different varieties available.



Nourishment Campbell's Soups contain selected meats and sea foods, best garden vegetables—carefully processed to help retain their natural flavors and nutritive values.

Convenience Within 4 minutes a bowl of delicious soup is heated and ready to eat.

Economy Campbell's Soups are inexpensive—an important consideration to those whose budgets are limited.

Recommend Campbell's Soups . . . and, of course, enjoy them yourself. Remember, *there's a soup for almost every patient and diet . . . and for every meal.*

NOW IS THE TIME... TO GIVE HER TIME WITH OVULEN-21®

Each tablet contains ethynodial diacetate 1 mg., mestranol 0.1 mg.



The new mother needs time...
to adjust to motherhood,
to give her new baby all the love
and attention he requires.
She needs time for her husband...
and for herself as well...
so that she can come to terms
with the increased cares
and responsibilities now facing her.
She needs time to decide
when she will have additional children
and how many she will have.

OVULEN-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

GIVES HER TIME

Your prescription for Ovulen-21 gives the new mother time to meet her family's present needs...to plan for her family's future.

She can take Ovulen-21 confidently and comfortably month after month. Its dependability is enhanced by its simplicity of use. A woman needs little or no time to learn the simple Ovulen-21 regimen: three weeks on—one week off. And the automatic record-keeping of the petite, virtually "patient-proof" Ovulen-21 Compack® helps to maintain her schedule...helps put time on her side.

Immediately post partum is the time

It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

It is also the most opportune time, since she is conveniently present in the hospital, for her to be given both instructions and a prescription.

Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Actions—Ovulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen depresses the output of both the follicle-stimulating hormone (FSH) and the lutenizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis and pulmonary embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates in the United States found relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable. Retrospective studies in Great Britain have shown a statistically significant association between cerebral thrombosis and embolism and the use of oral contraceptives. This has not been confirmed in the United States.



Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen. Therefore, if such tests are abnormal in a patient taking Ovulen, it is recommended that they be repeated after the drug has been withdrawn for 2 months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: Increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

1. Royal College of General Practitioners: Oral Contraception and Thromboembolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967.
2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968.
3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969.
4. American Journal of Epidemiology (to be published).

Where "The Pill" Began

G. D. SEARLE & CO., P.O. Box 5110, Chicago, Ill. 60680 SEARLE

972R

for the vitamin deficiency that diet alone doesn't satisfy...



Thera-Combex H-P®

This high-potency vitamin C and B-complex combination starts where diet stops

Kapseals®

Each Kapseal contains: ascorbic acid, 500 mg.; thiamine mononitrate, 25 mg.; riboflavin, 15 mg.; pyridoxine hydrochloride, 10 mg.; cyanocobalamin, 5 mcg.; niacinamide, 100 mg.; *dl*-panthenol, 20 mg.; Taka-Diastase® (Aspergillus oryzae enzymes), 2½ gr.



The Brown capsule with Green band is a Parke-Davis trademark.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

335R68



The Month in Washington

From the Washington Office
American Medical Association

Washington—The Senate Finance Committee approved a staff report on medicare and medicaid which was critical of both physicians and administration of the health care programs. It included a recommendation for fee schedules for physicians' services.

In a joint statement, the presidents of the American Medical Association and the National Medical Association pledged support of their organizations to the committee's efforts to correct deficiences and abuses in the two programs. However, the two spokesmen for organized medicine said "it would be tragic if . . . regulations were adopted whose effect would be to deny a greatly improved level of health care to the ghettos."

The AMA-NMA statement said that "we were greatly encouraged by the committee's comment that it 'believes that the majority of physicians for whom information was requested with respect to medicare and medicaid as presently structured have dealt fairly with these federal programs and with the federal government.'"

In regard to abuses and fraud, the statement said:

"Where these abuses exist, they must be rooted out. Both the AMA and the NMA are prepared to take very vigorous action within their power to help the committee and the government accomplish this."

It was noted that the committee had denied an AMA request many months ago that it be given the names of physicians involved in the committee's investigation.

"Despite this," the statement said, the AMA and the NMA through their own resources have been able to identify a number of physicians grossing more than $25,000 in these programs . . .

"In some instances, medical societies had already taken appropriate action against individual physicians where the evidence warranted. In other instances, however, the AMA and the NMA have found that many of the physicians presumably included in the committee's study are dedicated physicians working in isolation in slum and rural areas who are literally being overwhelmed by a tide of sick humanity . . .

"We therefore believe it would be unfortunate if the committee's report leads the public to believe that medicare and medicaid are riddled with fraud or that the number of physicians abusing the programs is large. Such is not the case . . ."

The report said that incomplete and partial listings indicated 4,300 individual practitioners plus an additional 900 physician groups who each received at least $25,000 from medicare in 1968, including 68 who received $100,000 or more. The report also included a long list of physicians by state receiving $25,000 or more from medicaid in 1968. None was named; listings were by code numbers.

* * *

"Hundreds of the payments profiles indicate that the physicians involved might be abusing the program," the report said. "For example, we found many general practitioners each paid $15,000, $20,000, or more for laboratory services. We found large payments being made for what appear to be inordinate numbers of injections. In many cases we found what is apparently overvisiting and gang-visiting of patients in hospitals and nursing homes.

The staff believes that the majority of physicians on whom information was gathered provided medically necessary services for

which they were entitled to charge and be reimbursed. On the other hand, medicare's payments structure did little to discourage—in fact, it encouraged—high fees, and thus may well have contributed to the very substantial payment totals to those same physicians."

Recently, the Social Security Administration reported that about 2,500 cases had been investigated for fraud or abuse during the first three and one-half years of medicare. It was emphasized that this was only a minuscule fraction of total medicare transactions. Social Security Commissioner Robert M. Ball said:

"Medicare pays about 30 million doctors' bills and 12 million bills from institutional providers of services each year. It is clear from our investigations that the number of attempts at fraud or abuse is relatively very small."

About half of the cases investigated, he said, resulted from clerical errors, misunderstandings or honest mistakes by physicians and health services. To Jan. 20, 1970, the SSA had referred the cases of 13 individuals and organizations to the Justice Department with recommendations for criminal prosecution for fraud. Two physicians have been convicted in U. S. district courts and indictments have been returned against another five physicians and one non-physician. Another five cases had been referred with recommendations that civil proceedings be started for the return of illegally collected funds. Early this year, social security investigators also were preparing an additional 35 possible fraud cases for referral to the Justice Department.

The most common types of alleged violations reported include physicians and providers billing for services not rendered, excessive charges, alteration of bills, duplicate billing, misrepresentation of types of services or dates of services, unreported discounts, or kickbacks, and employee embezzlement, medicare officials said.

The report's recommendations were aimed at providing "bases for remedying the serious, costly, and pervasive problems" of the two programs and make them "work more efficiently and economically." However, it was conceded that physicians constitute the cardinal factor.

"The key to making the present system workable and acceptable is the physician and his medical society," the committee staff said. "We are persuaded that at this point in time neither the government nor its agents have the capacity to effectively audit medical practice to assure that a given physician functions responsibly in dealing with the publicly financed programs.

"While there is growing awareness among many physicians of the need for the profession to effectively police and discipline itself, performance has been spotty and isolated so far. Prompt action is necessary by organized medicine (and other health professions) to do what is required with respect to monitoring care provided and charges made for the care . . .

"However, procedures which involve peer review should not be undertaken without precise spelling out and assurances that such review will be comprehensive and effective —not paper and token."

Report recommendations:

—Fee schedules for physicians' services.

—Generic prescribing of drugs.

—"Curb overutilization by requiring prior professional approval of elective procedures and expensive courses of treatment."

—Require the patient to name a "primary physician" to end "costly 'doctor shopping'."

—Require states to provide medicaid recipients with statements outlining payments made in their behalf.

—Modify present law "to make practicable reasonable cost-sharing payments by the medically indigent."

—Prohibit independent collection and dis-

count agencies from collecting medicaid or medicare due bills that providers have sold to them.

—Improve federal administration, and establish cooperative arrangements with and between states.

—Establish a medicaid fraud and abuse unit in HEW, and require states to establish similar units.

—Combine the medicare and medicaid advisory councils.

* * *

The American Medical Association urged changes in proposed federal regulations concerning fraud under the medicaid program.

"While we do not condone in any way any fraudulent conduct of physicians in Title XIX (medicaid) or in any professional activity, we do believe that physicians will consider the new requirements an unwarranted affront to their integrity in their participation in the program," Dr. Ernest B. Howard, executive vice president of the AMA, said in a letter to John D. Twiname, acting administrator of the medicaid program.

One of the proposed regulations would require physicians to sign form statements certifying that their claims were correct and that they understood fraud could subject them to prosecution.

These statements, Dr. Howard said, would serve no useful purpose because physicians already know that false claims could lead to prosecution. On the other hand, the regulation would be "regarded as offensive by many physicians since it obviously impugns their integrity," the AMA letter said.

The other proposed regulation would require state agencies to promptly report suspected cases of fraud.

"It is obvious that serious prejudice may result to a physician where the suspicion of fraud is publicized," the AMA said. "Even when the fraud is not later established, irreparable harm to the reputation of the physician will still have resulted . . . We believe it will be better procedure not to report each suspected case, but to include in the report only those situations where the case has been concluded and fraud has been established."

* * *

The Nixon Administration submitted a fiscal 1971 budget calling for federal expenditures of $20.6 billion from general revenues for health purposes, an increase of $1.8 billion over current spending levels. Medicaid and medicare Part B (physicians' services) accounted for much of the increase.

The overall medicare budget, including Part A (hospitalization), increased by $1.2 billion to $8.8 billion. Estimated medicaid costs to the federal government rose from $2.6 billion to $3.1 billion. However, the Administration hopes to cut the medicaid budget by $235 million by getting Congress to approve elimination of federal aid for extended care in mental institutions and nursing homes.

The budget for the current 1970 fiscal year, ending next June 30, still had not been approved when the new budget was submitted. Congress upheld President Nixon's veto of the appropriations for the departments of labor and of health, education and welfare on the ground that it was inflationary. The main funds at issue were educational aid for the federally impacted areas. The Administration and Congressional leaders negotiated a compromise.

In the 1971 budget, the lid was kept on health research spending by holding the overall increase in funds requested for the National Institutes of Health to $48 million. Some of the institutes' programs were cut and others given only small increases. Cancer research was allotted the largest increase, $28 million, pushing the 1971 budget for the program to $202.3 million. Heart research and child health research were increased by $17 million each.

Increases totaling $15.4 million were asked

for alcoholism and drug addiction programs.

The Food and Drug Administration budget was upped by 10 per cent, from $81.3 million to $89.5 million. Of this hike, nearly $2 million would be used to check safety of food additives and $2.2 billion for research on cancer and birth defects in animals exposed to pesticides.

A boost of $12.4 million, to $57.4 million, was requested for health services research and development projects "directed primarily at containing the rate of increase of medical care costs and improving the availability and utilization of health care especially for low income groups." The federal programs in this field include: the development of alternatives to long-term stays in hospitals; experiments with private insurance firms to develop additional policies to encourage out-of-hosiptal care; experiments with comprehensive prepayment plans; improvement of municipal hospital systems, and development of new types of health service manpower.

An increase of $25 million, to $320 million, was requested for health professions education and manpower training programs.

* * *

The pros and cons, with emphasis on the cons, of birth control pills were aired at a Senate subcommittee hearing.

Most of the physician witnesses at four days of hearings by the Senate Antimonopoly Subcommittee testified that not enough attention had been paid to side effects. They urged that both physicians and drug companies be more diligent in calling patients' attention to the possible dangers in taking oral contraceptives.

Some of the witnesses expressed strong concern or alarm as to side effects. Others defended the oral contraceptives.

Developments related to the hearings included:

—The Food and Drug Administration revived its birth control advisory committee which last fall concluded that the benefits of oral contraceptives outweighed the possible dangers so heavily that they could be evaluated as "safe." Dr. Roy Hertz, New York, N. Y., a critical witness before the subcommittee, was named temporary chairman.

—In advising physicians about the new labeling, the new FDA commissioner, Dr. Charles C. Edwards, urged that patients be given full information about potential adverse effects.

—The American College of Obstetricians and Gynecologists said it "deplored inaccurate or sensational reports concerning the scientific data on these drugs." The pills were termed "accepted therapeutic methods."

—Dr. E. B. Howard, executive vice president of AMA, in a televised interview, urged American women to be calm in the face of the wide publicity about side effects and follow the orders of their physicians.

—The AMA's Council on Drugs said: "Oral contraceptives should continue to be prescribed by physicians for patients who require this type of contraception. However, we urge that patients be advised that there are certain risks involved—the slight risk of vascular damage and the theorectical risk of carcinoma."

Advanced Cancer Therapies

The Ninth National Conference on Therapies for Advanced Cancers will be held Thursday to Saturday, Aug. 20-22, at the University of Wisconsin Post-Graduate Center, sponsored by the Division of Clinical Oncology, University of Wisconsin. Chairman of the program is Fred J. Ansfield, M. D., Professor of Clinical Oncology, and requests for information on the program should be addressed to R. J. Samp, M. D., University Hospitals, Madison, Wis., 53706.

The AMBAR® SCRAPBOOK of

Obesity Oddities

FACT & LEGEND

OBESITY WAS A MILITARY OFFENSE!

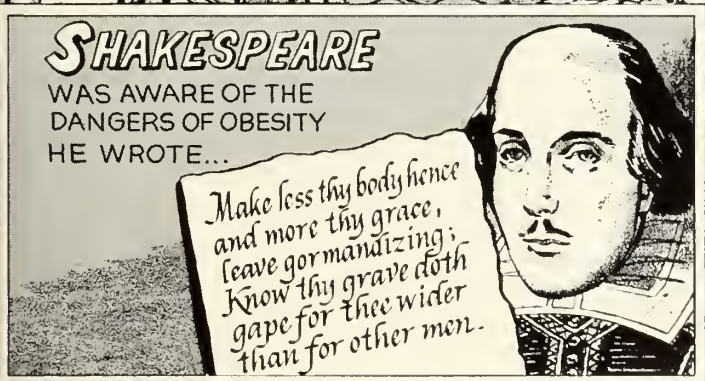
OVERWEIGHT ROMAN HORSEMEN WERE MADE TO FORFEIT THEIR MOUNTS AND BECOME FOOT SOLDIERS!

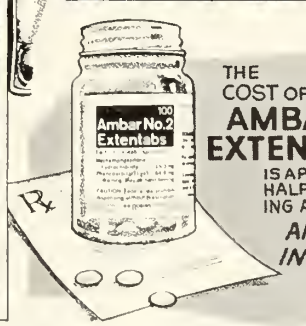


RECORDED ON AN ENGLISHMAN'S TOMBSTONE

SHAKESPEARE

WAS AWARE OF THE DANGERS OF OBESITY HE WROTE...





THE COST OF **AMBAR EXTENTABS** IS APPROXIMATELY ONE HALF THAT OF OTHER LEADING APPETITE SUPPRESSANTS

AN IMPORTANT FACTOR IN LONG TERM THERAPY

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS

Fathers and Sons in Medicine

"My Three Sons" Following in Their Dad's Footsteps

From the Biblical "Land of Milk and Honey," at the eastern end of the Mediterranean, famed for its towns of Tripoli and Cedars to the north, Tyre and Sidon to the south, and Beirut in the middle, came the parents of three, the grandparents of another three of the subjects presented here.

Lovely Lebanon, whose history runs back some 4,000 years before Christ, whose name appears in the Old Testament more than 60 times, whose cedars were used in the building of Egyptian tombs, of Roman ships, and Solomon's Temple, whose Temple of Jupiter survives in magnificent ruins to this day, with six of its original 54 imposing columns still standing, is remembered by Florian Emile Jabour, M. D., Montgomery, as the birthplace of his parents, the late Elias Jabour and Beulah Baroudy Jabour.

His grandmother Baroudy (which is Arabic for Brown), who came of a family of physicians and ministers, died last spring in her native Tripoli at the age of 107, alert to the last, playing a good game of bridge with Dr. Jabour's sister within the year.

Three of the Elias Jabours' five sons who survived to maturity earned their M. D. degrees and entered medical practice:—Robert, a general surgeon practicing in Tulsa, Okla., recently chief of staff and chief of surgery at Hillcrest Hospital; Ernest P. Jabour, who moved from his native Vicksburg, Miss., to Montgomery in 1946, practicing for 20 years until failing health forced his retirement two years before his death; and Florian Emile Jabour, who closed his general practice in his native Vicksburg in 1961 to join his brother Ernest in Montgomery.

But for a series of illnesses and deaths that pursued the Jabour family through the re-



Florian Emile Jabour, M. D., surrounded by sons: R. E. A., William, Ernest Elias, in that order.

covery years of the Depression, Emile Jabour might have written "The Rev." before his name instead of M. D. after it. It weighed heavily in deciding his future. His education included two years at Mississippi College, the famous little Baptist school at Clinton. There were 14 years' delay in his choice of a profession.

A member of Christ Episcopal Church from the age of four in 1918 to 1962, his principal interests have been his church and young people. In Vicksburg he was president of the Laymen's Club, Sunday School teacher and superintendent, Y. P. S. L. parish president, diocesan president, and provincial vice president; a licensed lay reader in Mississippi and Louisiana, a member of the choir, vestryman, and treasurer of his church. He was attending a YMCA Graduate School at Black Mountain College, Blue Ridge, N. C., when he met Maggie Etolia Lindsey. They were married five years later.

Ernest Elias Jabour, M. D., eldest of their three sons, presently is interning at Carra-

way Methodist Hospital, Birmingham, and will begin residency in Ob-Gyn. in July at University Hospital, Birmingham.

William Jabour II is a 1st year medical student at the University of Alabama in Birmingham.

And the younger of the three, R. E. A. Jabour (known as 'Rea'), is in the first year of his pre-med work at Auburn.

The Jabours' only daughter, Sara Ann, is receptionist-bookkeeper-doctor's assistant in her father's office.

Three Gipsons, M. D., Scattered In As Many States

But for a miracle that left one lone home standing in a sea of devastation, in the wake of the hurricane Camille, this particular entry in the Journal's Fathers-and-Sons-in-Medicine series might have been abruptly abbreviated.

There is a stretch of shoreline along the Mississippi coast between Pass Christian and Gulfport whose postoffice is Long Beach, Miss. A girl from there, whose maiden name was Linda Braun, is today Mrs. Charles Curtis Gipson—whose husband, father-in-law and brother-in-law are all doctors.

Dr. Charles C. Gipson is a resident in Ophthalmology at Tulane and they were visiting in Linda's native Long Beach when Camille roared out of the Gulf, across Ship Island, to vent its fury on the very area where they had elected to remain and "ride it out." When the winds passed and the sun returned, every home but theirs had vanished for as far as they could see, to the east and west of them. Four cars in their backyard were "totaled."

But this wasn't the first evidence of the fact that this younger of two doctor sons of Amos Carvel Gipson, Sr., M. D., would pursue that segment of medical practice pinpointed by the eye. Through his junior year of medical studies at the University of Munich, Germany, he was troubled with a deep-seated eye condition that defied diagnosis. He was about to drop out of Washington University's senior class, knowing that with diseased eyes he would be unable to keep up with his studies, and that failure might jeopardize his ever graduating in Medicine.



The Doctors Gipson in order of their age.

Fortunately at this time his condition was correctly diagnosed as aniseikonia, an "inequality of the retinal images of the two eyes," and the prescription was so complex that physicists at the American Optical Company had to write his prescription, thereby not only saving him for a career in medicine, but predetermining the specialty that he would follow with enthusiasm. Graduating with his M. D. degree from Washington University, he interned for a year in internal medicine at University Hospital, Birmingham, before serving two years in the Navy. Thereafter he started his Residency in Ophthalmology at Tulane, New Orleans, where he remains to now.

Both brothers were born in Gadsden, the elder-by-three-years, Amos Carvel Gipson, Jr., in 1936. Both sons received their baccalaureate degrees from Vanderbilt University, the older continuing in the same school for

four more years, to graduate Cum Laude with his M. D. degree in 1962.

He went on to intern in internal medicine at Ohio State University Hospital, Columbus, 1962-63. He told his father: "Every time I turned to extra reading that was intensely interesting, the subject was the human brain." So, in the natural course of events, he became a resident in Neurology at Duke University Hospital, in Durham, 1963-65, and the following year the chief resident in Neurology at the University of Miami Hospital, 1965-66, finally crossing the Atlantic to become a Neurology resident in Queens Square Hospital, London, 1966-67.

In the private practice of Neurology in Tampa, Fla., since 1967, this Dr. Gipson is married to the former Dorothy Murazewski, whose family brought her to this country from Germany 13 years ago.

Neither couple, incidentally, has made the Gipson parents grandparents. Which serves to introduce their father:

Amos Carvel Gipson, the senior of that name, was born in Fyffe, Alabama, in DeKalb County, on Thursday, May 28, 1903. He earned his baccalaureate from the University of Alabama in 1925, and two years later his M. D. degree from the University of Illinois—so far as he knows, the first member of his family to choose Medicine as a career.

He interned first in 1927-28 in Hillman Hospital, Birmingham; was Assistant Resident in Pediatrics at New Haven (Conn.) Hospital, 1928-29; and in the time of the Stock Market collapse, 1929-30, was a Resident in Pediatrics at Strong Memorial Hospital, Rochester, N. Y.

After 35 years of private practice in Pediatrics in Gadsden, 1930-65, Dr. Gipson found that the pressures of private practice were becoming not only annoying but threatening. So then is when he became Staff Physician for the mentally retarded at Partlow State Hospital, Tuscaloosa, where he has remained since.

When he initially took up practice in Gadsden, by the way, he was moving across the county line from DeKalb to Etowah, and Gadsden, which happened to be the native town of Mrs. Gipson, the former Virginia Barret.

The senior Gipson's hobbies are golf and fishing, to which his younger son Charles adds hunting. But all-absorbing hobby of Amos, Jr., is sailing—which is as good a reason as any why he has located his practice on the shores of Tampa Bay.

Not just a motel
it's a Guest House

. . . with 171 handsome rooms designed for your comfort and convenience. A center-of-everything location including Birmingham's University of Alabama Medical Center . . . making The Guest House a favorite of Doctor's wives and in-town outpatients. Superb dining, dancing and nightly entertainment. Come stay with us often.

THE RESTAURANT
THE PLAYROOM • CYPRESS ROOM
CONVENTION FACILITIES



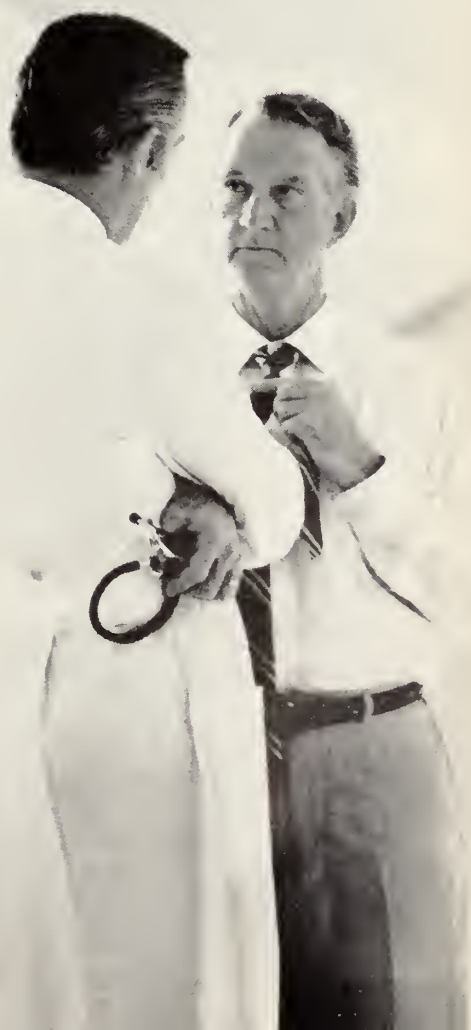
The Guest House
MOTOR INN

PHONE 324-8653
18TH ST. &
10TH AVE., SOUTH
BIRMINGHAM, ALABAMA

"Where the Action Is!"

Mylanta®
24 million hours a day.

Through the day, every day,
ulcer patients take
one million doses of Mylanta
for relief of ulcer pain.



Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides plus simethicone

Good taste = patient acceptance
Relieves G.I. gas distress*
Non-constipating

*with the defoaming action of simethicone

Stuart PHARMACEUTICALS Pasadena, Calif. 91109
Division of Atlas Chemical Industries, Inc., Wilmington, Del. 19899

Hobbies To Fill A Doctor's Leisure

The City Dump May Hide A Treasure Trove!

"Antique" means simply ancient or old. And age is purely relative. A California Redwood twice the age of Methuselah may be still in the blush of youth. A butterfly is old before the day is done.

So a "young" antique is not a contradiction. And one of the youngest of the antique groups is the handmade bottle, which was still being produced in quantity as recently as 1910.

Because the great mass of antique bottles was once filled with patent medicines, elixirs, remedies, panaceas, bitters and "cures" of all kinds, it is appropriate that the practicing physician should find bottle collecting a related and fascinating leisure-time pursuit.

Because a Mobile doctor changed his hobby from "politics to privies," this particular hobby was first suggested. Sidney Clarke Phillips, Jr., M. D., had been recommended originally for inclusion in last month's hobby, politics. While Dr. Phillips agreed that he was still heavily involved in the intricacies of the ballot box (he is on the school board!), he had long since abandoned it as a pleasant leisuretime pursuit. And when he spoke of "turning from politics to privies," it wasn't entirely an alliterative gag. The abandoned, over-grown, filled-in and forgotten outhouse pit from the 19th century and before is a favorite source of all kinds of bottles, especially those that once held tonics, patent-medicines and bitters.

"Bitters," Dr. Phillips will explain, "was a tax dodge." Containing a *high* percentage of alcohol, the addition of a few drops of herb extract and the labeling of it "bitters," took it off the whiskey tax list!

Dr. Phillips mentioned a friend and fellow enthusiast, James Elijah Morris, Jr., M. D., a psychiatrist with Bryce Hospital, Tuscaloosa.



IT'S A FAMILY AFFAIR, hunting bottles as a hobby, for the five Mobile Phillips—Dr. and Mrs. Sidney C. Phillips, Jr., and their three children, two of whom shown here are Charles and Mary. Sidney III is missing from the picture.

Born in Mobile, the son of an educator for whom a Mobile school is named, Dr. Phillips comes of a line of ministers on both sides of his family. His paternal grandfather was the internationally known Southern Baptist minister, the Rev. Dr. John W. Phillips, in his latter years pastor of the First Baptist Church of Mobile. His mother, the former Kate Tucker of Mobile, was the daughter and niece of noted Episcopal rectors, the Revs. Louis and Gardner Tucker. And the current subject's younger brother, the Rev. John W. Phillips, named for their noted grandfather, is also an Episcopal minister.

Dr. Sidney C. Phillips, Jr., is married to



THERE'S A LOT OF HARD WORK attached to the pursuit of old bottles as a hobby. Three views of Dr. James E. Morris, Jr., Tuscaloosa, illustrate the fact. Two pictures show him in the field, and one shows him busy classifying new acquisitions, seated before a collection that threatens to crowd him out of his display rooms in the basement of his home. The two closeups are a sampling of bottles in his collection. This is a family hobby for the Morrises, too.

the former Mary Houston of Mobile, and they have three children: Mary, Sidney III, and Charlie.

Some of Dr. Phillips' bottle finds have been highly valuable, particularly several historical flasks, and some bitters bottles, many of them made and originally bottled in Mobile. Bitters manufacturers were in Mobile in large numbers, and probably in Montgomery too, he says.

His friend and frequent associate on bottle hunts, James E. Morris, Jr., M. D., is a native of Memphis, with his baccalaureate from Memphis State, his M. D. from U. T. He is

married to the former Phyllis Chandler and they too have three children: James E. III, Debbie, and Tommy.

Dr. Morris writes so interestingly of his hobby that the rest of this feature is his:

"Early in our marriage my wife and I began collecting antique items, finding ourselves involved in an ever increasing interest in things from the past. The individual craftsmanship and hand-made qualities, even primitive or crude at times, give these items a uniqueness compared with the mass-produced and machine-made look of today. Old bottles also fall into this category for it wasn't until around 1910 that the bottle machine became generally used, turning out the precision-made sameness of product we know today. The usual definition of an antique bottle is that it was produced by hand, which can be readily distinguished from the manufactured glass. In our collecting of old things, we had accumulated a number of bottles over the years.

"Then, about three years ago, I met a faculty member of the University of Alabama who told me of his digging for old bottles and invited me to join with him and several other enthusiasts on their next dig. They had located what I later learned was one of the ideal places to find old bottles—a long abandoned town dump on the banks of the Alabama River. This dump had been used from the early 1800's until about 1900, so all bottles found could be classified as antique.

"This first digging experience really hooked me, and I've become not only a more avid bottle collector, but also a digger. I've found that locating potential digging sites requires a great deal of researching historical records, old maps, old newspapers, etc. One by-product of this hobby is that one becomes a student of history. Articles by such people as Dr. Peter Brannon, Matt Clinton, and other state and local historians have helped immensely to provide data for current explorations.

"Just a few weeks after my first encounter with bottle-digging, I learned that another physician in Alabama, Dr. Sidney Phillips of Mobile, was also an enthusiastic bottle collector and digger. I have made several trips to Mobile to dig with him and to learn the art of digging out old privy holes, which is one of the chief sources of antique bottles there. Most of the older (even back to 1700's) and cruder bottles found in Alabama are from Mobile due to its being one of the oldest towns.

"My collection consists only of bottles made by hand. There are many different types—inks, mineral waters, beers, whiskies, sodas, patent medicines, druggists, household products, etc. Many bottles of this age carry embossing in the glass which makes identification of its use much easier. Of primary interest to me are the patent medicines which were produced before the 1906 Pure Food and Drug Act. During the latter half of the 19th Century, it is estimated there were as many as 100,000 different remedies, cures, panaceas, etc., on the market. This is the era of the bitters, sarsaparillas, Indian cures, etc. Often the embossing or the labeling describes dramatic therapeutic or curative claims for what the contents (usually it was alcohol, herbs, opium, and almost always purgative in its action) would do. Collecting these gives you a glimpse into times past when the art of medicine was without its present scientific sophistication and the folk remedies and cures prevailed. The anxieties of the people about illness and poor health at that time are obvious from the large number of patent medicines which thousands of enterprising promoters made available. A few examples of some of the colorful 'medicines': 'Bradfield's Female Regulator—Woman's Best Friend,' 'Lightning Hot Drops—No Relief No Pay,' 'Renne's Magic Oil,' 'Hamlin's Wizard Oil,' 'Hicks Capudine Cures All Headaches, Grippe, Indigestion, Etc.,' 'Kendalls Spavin Cure for Human Flesh,' 'Radway's Sarsaparillian Resolvent,' 'Roche's Embrocation for the Hooping Cough', 'Silver Pine Healing Oil,' 'Cuticura System of Curing Constitutional Humors.'

"Over the past three years, our family collection has grown to over 2,000 different antique bottles, about a fourth of them 'patent medicines'. Approximately 95 per cent of these were dug up by the family, for often a digging trip is a family outing.

"Across the country, bottle collectors have formed clubs, and bottle shows, sales, and swaps are now regular events. A recent survey showed this to be the third most popular collecting hobby in the country, behind stamp and coin collecting only.

"All in all, collecting antique bottles can mean a combination of preserving historical items and appreciating the craftsmanship and artisan ability of man before the era of machines and mass production. There is the physical involvement with the excavation by hand and exploration of potential digging sites. There is the learning about local history—people, places, and life as it was for our ancestors. There is the enjoyment of an activity which can involve and appeal to all family members. There is the thrill of discovery and the disappointment of empty-handedness at the end of a day. Bottle collecting means all of these things to me."

Books of Interest to Doctors and Laymen

TO SMOKE OR NOT TO SMOKE, by Luther L. Terry, M. D., and Daniel Horn, Ph. D., with the assistance of Madelyn Ferrigan, M. D., Lothrop, Lee and Shepard, New York, 64 pages—$3.75.

Why do people start smoking? Why do people go on smoking? What does smoking do for you? What are a smoker's chances of disability, disease, or death? Whom does smoking hurt the most? Does air pollution cause lung cancer? Will stopping lessen the harm smoking has done already? Is there such a thing as a safe cigarette?

These are some of the questions answered in this gem of a little book, aimed particularly at young people of 12 years old and up, but a mighty weapon in the hands of any crusader against the tobacco habit.

The cigarette industry spends about $70 million more a year on television advertising than the automobile industry, the second largest advertiser. "The Federal Trade Commission, in its 1968 Report to Congress, estimated that our nation's 22,500,000 teenagers between the ages of 12 and 17 saw an average of 61 cigarette-sponsored television commercials in the month of January, 1968." And every one of them promoted the idea that "cigarette smoking is both pleasurable and harmless."

Cigarette availability is to be found at almost all kinds of sales outlets, particularly vending machines, which, comments this book, "make a mockery of laws that exist in every state prohibiting the sale of cigarettes to minors."

There are many rewards for not smoking or for stopping smoking, but there is nothing quite comparable to the self-satisfaction of a parent who broke the habit before a child followed in his footsteps.

—W. J. M., Jr.

Montgomery Doctor Flying "Instrument Rated" at 70

Although Harry Norman and "Pete" Peterson were senior citizens when he was just past half a century old, Daniel LaSalle Hagood, M. D., can boast a distinction that may be a record in aviation history.



DR. M. H. HAGOOD
With Grandchild

Dr. Hagood was in the 70th year of his life when he obtained his "instrument rating."

For those "earthlings" unfamiliar with the term, instrument flying is flight in which navigation is carried out by the use of flight and navigational instruments without visual reference to the ground. And if there is anyone in aviation history before Dr. Hagood who had passed seven decades of life before qualifying under federal examination, I don't know of him.



Dr. Hagood with flying instructor Ralph Wiles before the Hagood plane.

The Montgomery ophthalmologist is, however, no johnny-come-lately with his interest in aviation. He went into the Army Air Corps (or more properly, what was then the Signal Corps) in World War I with an eye to flying combat against the enemy. It was not his fault that he never got into the first stage of flight training. He would have to wait 28 years, until he was in his late 40's, before beginning instruction.

Daniel L. Hagood was born at Mt. Willing, Ala., June 11, 1899, the son of a young doctor —Middleton Howard Hagood, M. D. (Which, parenthetically qualifies these two for inclusion in the Journal feature, "Fathers and Sons in Medicine"). He received his M. D. degree from Tulane in 1925, and the next year joined his father in practice in Brewton. The senior Dr. Hagood, by the way, was also a World War I veteran, going to France in the Medical Corps, where he was thrown with such prominent Alabamians as Gen. Robert E. Steiner of Montgomery and Lt. Frank M. Dixon, Birmingham, destined to become the 42nd Governor of Alabama.

Dr. Daniel L. Hagood married the former Anna Laura Dunn of Mobile. One son, Dan, Jr., was born to their marriage, and although this son did not follow his father into medicine, he did inherit an absorbing interest in flying. And in fact the two flew together in their own plane to Alaska in 1962 to attend the Flying Physicians Association meeting in Anchorage. That convention, by the way, drew 35 planes carrying more than a hundred persons from the continental United States.

Dan, Jr., who runs a cattle farm in Lowndes County, shares his Cessna 180 with his father. Married to the former Evelyn Stefanik of Massachusetts, he is the father of three children:—Dan III, 15; John 7; and Laura, 5.

For non-Montgomerians unfamiliar with the two names mentioned in the first paragraph of this article, Harry Norman had rounded out four-score years of life, still fly-

ing, when he was fatally injured in an airplane accident; John A. (Pete) Peterson, who missed flying instruction in the Air Corps in World War I, settled in Montgomery, made a fortune in bridge construction, was an enthusiastic flier until he was grounded by federal inspectors for health reasons, died two years ago, leaving three quarters of a million dollars to the Kiwanis Club of Montgomery.

The half column picture shows Dr. Middleton H. Hagood holding his grandson in his lap. This was in 1927, when Dan, Jr., was 6 months old.

Looking Inside U. S. Ice Box

The December issue of *Alaska Medicine*, rounding out its fourth year of joint publication by the Alaska State Medical Association and the Alaska Dental Society, is an excellent example of a little magazine packed with fascinating articles. For instance: "On Abortion, A Dissent," by J. Paul Dittrich, M. D., who argues eloquently that "artificial interruption of pregnancy is not only an unnatural act but an immoral one as well." And "The Village Medical Aides—Alaska's Unsung, Unlicensed and Unprotected Physicians," by Paul Eneboe, M. D.

One dentist contributes an article on "Fluoridation For Seward," another on "Aurora Dentatus."

There are other highly interesting pieces. And the cover, spread across opened front and back is a striking color photograph of a beached and abandoned tugboat, parked in front of a railles pier, with water in the foreground, water in the background, and dominating the scene are towering snowcaps. The clearly discernable name of the tugboat: "Try Again."

Private Opinion: Who's Discriminating Against Whom?

Commenting on the trend to equality with a corresponding lowering of scholastic qualifications, Marvin Henry Edwards, editor of *Private Practice*, a magazine published monthly in Oklahoma City, italicizes the following thoughts:

It is irrelevant that intellect does not equal character superiority; nor is it relevant whether minority groups are or are not more frequently found in lower or higher scholastic ranges. All that is relevant, really, is the competence of the final product: the practicing physician . . .

And there is another point too. In the long run, the person most discriminated against will be the patient . . .

So, with lower standards they will be admitted; with lower standards they will be graduated; with lower standards they will practice. The victim of it all is, ultimately, the patient.

Mr. Edwards urges that through private, corporate and charitable scholarships, for which the needy compete openly, and with competent teaching staffs, only the worthy and the promising find a way there. "This will:"

1. Produce more long-lasting and real results in the upgrading of the educational and financial status of the poor and minority groups;

2. Do away with discrimination against the non-poor and non-minority students.

3. Eliminate the risk that in playing the game of social equality, we will endanger the quality of medical care being given to all Americans.



around the state

Vital Statistics

NEW MEMBERS

Cherokee County

Adams, John Gramling, b 39, mc Alabama 66, recip. NBME 69, Cedar Bluff Road, Centre, Alabama 35960.

Perry County

Merkle, Bobby Charles, b 36, mc Alabama 60, sb 64, Uniontown, Alabama 36786, (Transfer from non-member Perry County to member Perry County.)

Talladega County

Brasfield, Milton Stanhope, III, b 37, mc Alabama 64, sb 65, 308 West Hickory Street, Sylacauga, Alabama 35150.

MEMBERS DECEASED

Lee County

Samford, Millard W., Opelika Ala. deceased.

CHANGES OF ADDRESS

Covington County

O'Neal, J. Paul, present Florala to 202 George C. Wallace Drive, Enterprise, Alabama 36330.

Williamson, Paul S., present Andalusia to Summit, Mississippi 39666.

Jefferson County

Casten, Gus G., present Birmingham to 2936 Donita Drive, Birmingham, Alabama 35243.

Farmer, Harry R., present Fairfield to 680 Noland Place, Fairfield, Alabama 35064.

Gay, Madison Waller, present Birmingham to 1521 16th Avenue, South, Apt. J, Birmingham, Alabama 35205.

Kent, John E., present Birmingham to 438 Professional Building, 801 Princeton Avenue, Birmingham, Alabama 35211.

Naramore, Malta L., Jr., present Birmingham to 2020 15th Avenue, South, Birmingham, Alabama 35205.

Preston, Roy T., Jr., present Fairfield to 701 Princeton Avenue, S. W., Birmingham, Alabama 35211.

Yeargan, Wilfred W., present Birmingham, to 914 5th Avenue, East, Tuscaloosa, Alabama 35401.

Lee County

Knapp, Byron S., present Auburn to Drake Infirmary, Auburn University, Auburn, Alabama 36830.

Madison County

Clanton, Jerry N., present Huntsville to Medical Center Hospital, 911 Big Cove Road, Huntsville, Alabama 35801.

Goodson, William H., Jr., present Huntsville to 507 Owens Drive, Huntsville, Alabama 35801.

Mobile County

Fonde, William G., present Mobile to Scott Paper Company, P. O. Box 2447, Mobile, Alabama 36601.

Montgomery County

Cobbs, Beverly W., present Montgomery to

(Continued on Page 863)



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

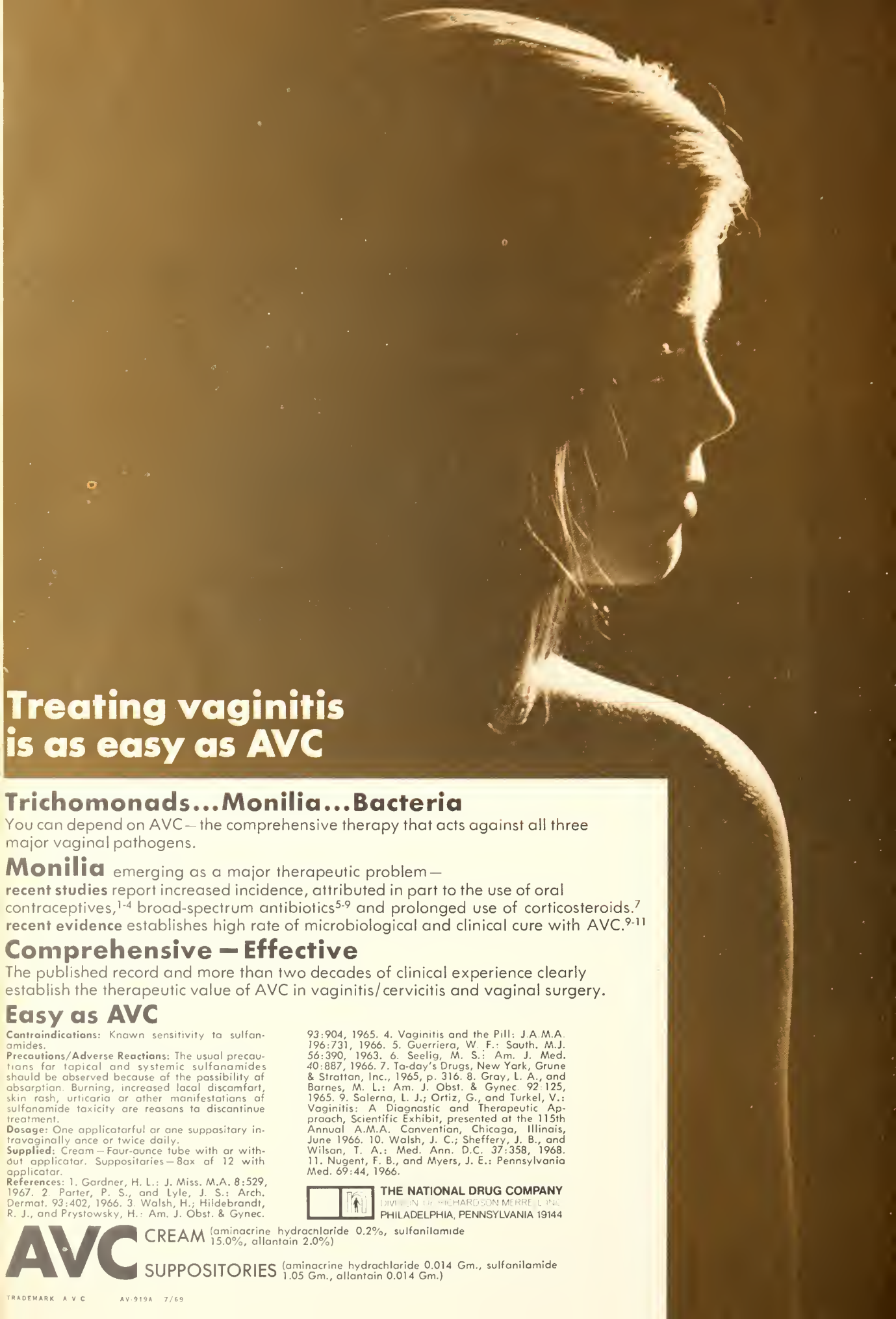
One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Compasitian: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminaphylline, 195 mg. **Indications:** For the preventian and treatment af nacturnal and recumbency leg muscle cramps, including thase associated with arthritis, diabetes, varicase veins, thrambaphlebitis, arteriasclerasis and static faat deformities. **Cantraindications:** QUINAMM is cantraindicated in pregnancy because af its quinine cantent. **Precautians/Adverse Reactions:** Aminaphylline may produce intestinal cramps in same instances, and quinine may produce symptoms af cinchanism, such as tinnitus, dizziness, and gastraintestinal disturbance. Discantinue use if ringing in the ears, deafness, skin rash, ar visual disturbances accur. **Dosage:** One tablet upan retiring. Where necessary, dosage may be increased ta ane tablet fallawing the evening meal and ane tablet upon retiring. **Supplied:** Battles af 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps



Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive—Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfanamides.
Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfanamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfanamide toxicity are reasons to discontinue treatment.
Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriera, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. Ta-day's Drugs, New York, Grune & Strattan, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerna, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnastic and Therapeutic Appraach, Scientific Exhibit, presented at the 115th Annual A.M.A. Canventian, Chicaga, Illinais, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilsan, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

AVC CREAM (aminacrine hydrachlaride 0.2%, sulfanilamide 15.0%, allantain 2.0%)
SUPPOSITORIES (aminacrine hydrachlaride 0.014 Gm., sulfanilamide 1.05 Gm., allantain 0.014 Gm.)

TRADEMARK A V C
AV-919A 7/69

(Continued from Page 860)

3202 Bankhead Avenue, Montgomery, Alabama 36104.

Cium, Gertrude L., present Montgomery to 1301 East South Boulevard, Montgomery, Alabama 36111.

Crum, William B., present Montgomery to 1301 East South Boulevard, Montgomery, Alabama 36111.

Morgan County

Hawkins, Rowland D., present Hartselle to Physicians & Surgeons Clinic, P. O. Box 31, Highway 31 North, Hartselle, Alabama 35640.

Walker County

Ray, Robert E., present Jasper to P. O. Box 1389, Jasper, Alabama 35501.

Schlitt, Robert J., present Jasper to P. O. Box 1389, Jasper, Alabama 35501.

Washam, James M., Jr., present Jasper to 601 South Street, Talladega, Alabama 35160.

NEW TELEPHONE NUMBERS

Byrne, Thomas K., Jr. Montgomery	288-0392
Dunn, Julius E., Elmore	567-9850
Dunn, Julius E., Jr., Elmore	567-9850
Glenn, Leslie E., Tuscaloosa	345-6960
Knapp, Byron S., Lee	826-4416
McGowan, Eoline I., Jefferson	934-5384
Pack, Milton, Morgan	355-1616
White, Jerre R., Tuscaloosa	345-6960
Williams, Thomas H., Jr., Montgomery	288-7701
Zumstein, Robert F., Dale	762-2305
Hawkins, Rowland D., Morgan	773-2501

TRANSFERS

Jefferson County

Moore, Ewing Jones, Jr., 800 Montclair Road, Birmingham, Alabama 35213. (Transfer from member to non-member).

CHANGE OF SPECIALTIES

Jefferson County

Blankenship, Brantle E., 1620 14th Avenue, South, Birmingham, Alabama 35205—Psychiatry.

Guffin, Gilbert T., 224 Ardella Circle, Birmingham, Alabama 35207—Anesthesiology (resident).

Hirschowitz, Basil I., 1919 7th Avenue, South, Birmingham, Alabama 35233 — Internal Medicine-Gastroenterology.

Roy, Barbara Jean, 800 Monclair Road, Birmingham, Alabama 35213—Anesthesiology.

Tucker, Mylan S., 700 Memorial Drive, Bessemer, Alabama 35020—Surgery.

Ward, John L., 1025 South 18th Street, Birmingham, Alabama 35205—Psychiatry.

(Continued on Page 865)

Course In Laryngology

The Department of Otolaryngology of the Eye and Ear Infirmary of the University of Illinois Hospital and the College of Medicine of the University of Illinois at the Medical Center, will conduct a postgraduate course in Laryngology and Bronchoesophagology from April 6 through 17, 1970. This course is limited to 15 physicians and will be under the direction of Paul H. Holinger, M. D. It will be held largely at the Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of other Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, College of Medicine, University of Illinois at the Medical Center, Postoffice Box 6998, Chicago, Illinois 60680.



The Bradley Center --- for the problems of living

An all new homelike open psychiatric residence on a lovely five-acre tract, centrally located within the community, providing a comprehensive range of continuous services, including in-patient, day care, and outpatient treatment. Each patient participates in an extensive and intensive treatment program, based almost exclusively upon multiple psychotherapeutic encounters. These include individual psychotherapy, group psychotherapy, the nursing milieu, occupational therapy, recreational therapy, topical small group discussions, and other group activities in the Center, as well as in the community, depending on individual needs and interests. Medications are prescribed when appropriate.

Any individual may be admitted who, in the opinion of the medical staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible family member.

Accredited by the Joint Commission on Accreditation of Hospitals.

Leonard T. Maholick, M. D.
Medical Director

Maj. Gen. (ret.) Howard Snyder
Administrator

THE BRADLEY CENTER, INC.
2000 Sixteenth Avenue
Columbus, Georgia 31901
Area Code 404 324-4882

New Physicians Licensed To Practice In Alabama



Arthur George Aaronson, M. D., University of Vermont College of Medicine, 1964, Reciprocity with NBME—Intends to locate at Fort Benning, Georgia.



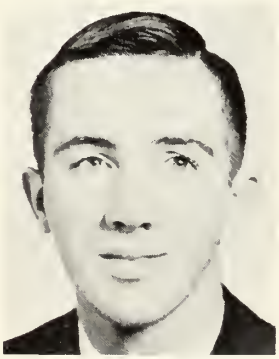
William Othel Bryant, M. D., University of Tennessee College of Medicine, 1956, Reciprocity with Tennessee—Intends to locate in Livingston, Ala.



George Louis Auman, M. D., Bowman Gray School of Medicine, 1968, Reciprocity with North Carolina—Intends to locate in Birmingham.



Albert Steven Cain, M. D., Medical College of Alabama, 1968, Reciprocity with NBME—Intends to locate in Birmingham.



Perry William Aycock, Jr., M. D., Medical College of South Carolina, 1968, Reciprocity with NBME—Intends to locate in Birmingham.



Jacob David Caldwell, Jr., M. D., University of Tennessee College of Medicine, 1956, Reciprocity with Tennessee—Intends to locate in Livingston, Ala.



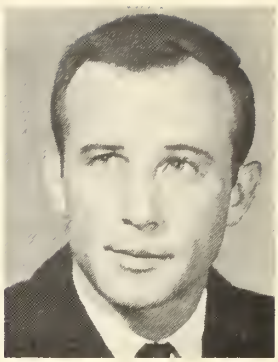
David Barton, M. D., Tulane University School of Medicine, 1969, Reciprocity with Louisiana—Intends to locate in Selma, possibly.



William Henry Clark, M. D., University of Missouri School of Medicine, 1966, Reciprocity with Missouri—Intends to locate at Fort Rucker, Ala., and Daleville, Ala.



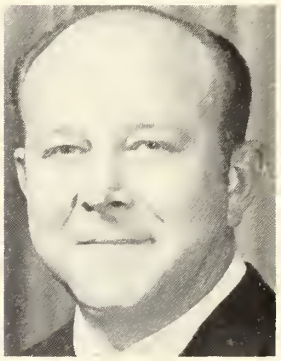
John Webster DeGroote, M. D., University of Iowa College of Medicine, 1962, Reciprocity with NBME—Intends to locate in Birmingham.



Edward Joseph Flynn, Jr., M. D., University of Mississippi School of Medicine, 1963, Reciprocity with Mississippi—Intends to locate in Mobile.



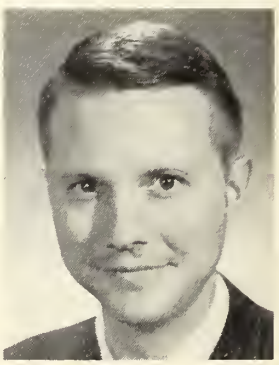
Allan Jay Dinnerstein, M. D., Albert Einstein College of Medicine, 1964, Reciprocity with NBME—Intends to locate in Foley or Brewton, possibly (stationed at Pensacola).



Edward Lester Gegan, M. D., University of Tennessee College of Medicine, 1958—Reciprocity with Tennessee (Surgeon)—Intends to locate in Livingston, Ala.



Percy Elford Dunagin, Jr., M. D., Loma Linda University, 1968, Reciprocity with NBME—Intends to locate in Birmingham.



William Cornelius Greenman, M. D., University of Florida College of Medicine, 1968, Reciprocity with NBME—Intends to locate in Birmingham.



Peter Cummins Dyke, M. D., Duke University School of Medicine, 1960, Reciprocity with North Carolina—Intends to locate in Birmingham.



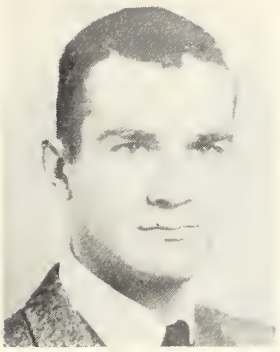
John Michael Grelier, M. D., Medical College of Alabama, 1968, Reciprocity with NBME—Intends to locate in Birmingham.



Robert Edwin Elliott, M. D., University of Arkansas School of Medicine, 1965, Reciprocity Arkansas—Intends to do part-time practice in Atmore (stationed at Pensacola).



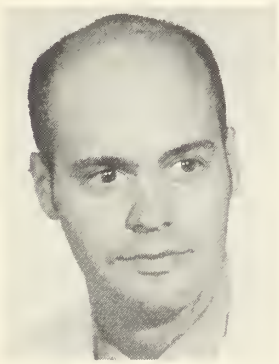
Henry Thomas Gunter, M. D., Tulane University School of Medicine, 1959, Reciprocity with Mississippi—Intends to locate in Mobile.



Richard Marvin Hutson, M. D., Vanderbilt University School of Medicine, 1966, Reciprocity with NBME—Intends to locate in Huntsville (Redstone Arsenal).



Daniel William Pieroni, M. D., Indiana University School of Medicine, 1965, Reciprocity with Indiana —Intends to locate in Sheffield.



Roger Kenneth Lewis, M. D., Cornell University Medical College, 1966, Reciprocity with NBME —Intends to locate in Birmingham.

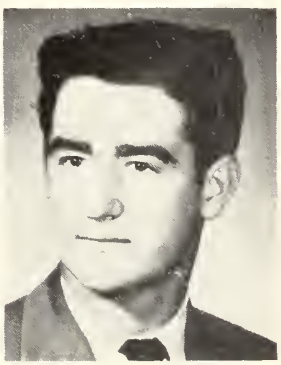


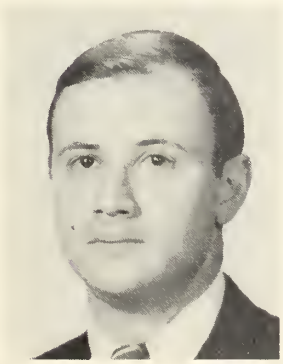
Martin Plotkin, M. D., Chicago Medical School, 1964, Reciprocity with NBME—Intends to locate in Montgomery (Maxwell AFB).

Daniel Thompson McCall, III, M. D., Medical College of Alabama, 1967, Reciprocity with NBME —Intends to locate in Birmingham.

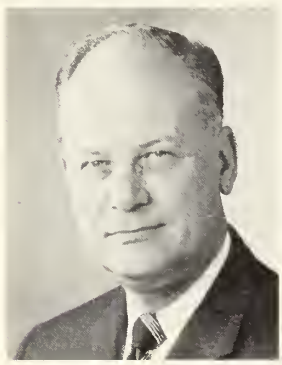


Leonard George Prutsok, M. D., West Virginia University School of Medicine, 1968, Reciprocity with NBME—Intends to help in Brewton (US Navy, Pensacola).





Christopher Wehby Norwood, M. D., Medical College of Alabama, 1968, Reciprocity with NBME —Intends to locate in Birmingham.



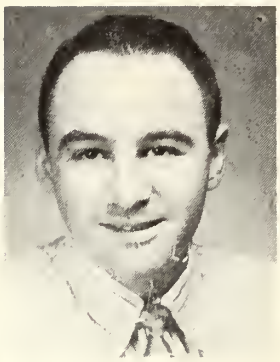
Paul Irwin Robinson, M. D., Washington University School of Medicine, 1928, Reciprocity with NBME—Intends to locate in Montgomery.

Maunsel Bennett Pearce, Jr., M. D., Tulane University School of Medicine, 1963, Reciprocity with Louisiana—Intends to locate in Montgomery (Maxwell AFB).

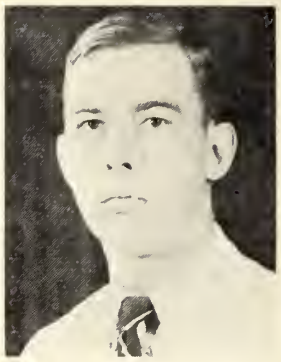


Elbert Max Sanders, M. D., Medical College of Alabama, 1967, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.

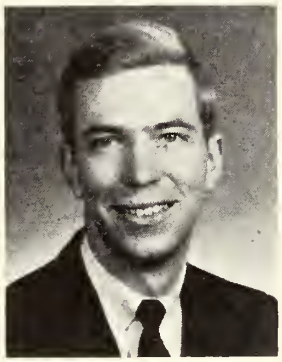




Stephen Alexander Dickson Schuster, M. D., University of Texas Medical Branch (Galveston), 1965, Reciprocity with Texas—Intends to locate at Fort Rucker.



Alvin Julian Weber, III, M. D., University of Tennessee College of Medicine, 1962, Reciprocity with Tennessee—Intends to locate in Sheffield.



Howard Carey Snider, Jr., M. D., Medical College of Alabama, 1968, Reciprocity with NBME—Intends to locate in Birmingham.



Horace Roger White, Jr., M. D., Medical College of Alabama, 1968, Reciprocity with NBME—Intends to locate in Birmingham.



Stonewall Boulet Stickney, M. D., Tulane University School of Medicine, 1947, Reciprocity with Louisiana—Intends to locate in Montgomery.



Julius Howard Stokes, Jr., M. D., Medical College of South Carolina, 1967, Reciprocity with South Carolina—Intends to locate at Fort Rucker.



Gilbert Wayne Taylor, M. D., University of Arkansas School of Medicine, 1960, Reciprocity with Arkansas—Intends to locate in Livingston, Ala.

Otolaryngologic Assembly

The Annual Otolaryngologic Assembly of 1970 will be held Sept. 19 through 25, in the Eye and Ear Infirmary of the University of Illinois Hospital. The Department of Otolaryngology, College of Medicine, University of Illinois at the Medical Center, offers a condensed postgraduate basic and clinical program for practicing otolaryngologists under the direction of Doctor Emanuel M. Skolnik. It is designed to bring to specialists current information in medical and surgical otorhinolaryngology.

A separate, but correlated course "Conference on Radiology in Otolaryngology and Ophthalmology" will be held this year on Friday and Saturday, Nov. 27 and 28, under the guidance of Doctor Galdino E. Valvassori. For further information about the radiology conference, write to Prof. Valvassori, Radiology Department, College of Medicine.

Interested otolaryngologists should direct their inquiries to the mailing address:

OTOLARYNGOLOGY
P. O. Box 6998
CHICAGO, ILLINOIS 60680



Blue Shield's new URC program recognizes your "out-of-the-ordinary" charges through individual consideration by review committees composed of physicians.

BLUE CROSS-BLUE SHIELD OF ALABAMA

®

1 Of 10 In 50-Year Club

Although only one doctor of the ten members of the Medical Association qualifying for membership in the 50-Year Club in 1970 was born in 1895, this happens to be the *average*. The ten received their M. D. degrees in 1920.



Dr. L. G. Woodson, Jr.

One doctor was born in 1891, one each in 1892, in 1893, in 1894, in 1895, and in 1896; three in 1897, and one is comparatively a mere lad, born in 1898.

The one in the middle is Lewis Green Woodson, Jr., born in Birmingham on Thursday, June 13, 1895. He was graduated from high school in 1913 and attended the University of Alabama two years, before going on to what was then the Jefferson Medical College of Philadelphia, from where he received his M. D., interning subsequently at the Protestant Episcopal Hospital in Philadelphia.

The son of a doctor, Dr. Woodson qualifies for the Journal's well-received feature, "Fathers and Sons in Medicine," but he only comments: "That was a long time ago," and doubts that "Any other doctors will be interested in my story."

Dr. Woodson's wife is the former Mary Sharp of Nauvoo, Ala., and their only son, Lewis Green Woodson III, chose not to follow his father and grandfather into medicine.

To Ligate or to Tie

I would never use a long word, ever, where a short one would answer the purpose. I know there are professors in this country who "ligate" arteries. Other surgeons only tie them, and it stops the bleeding just as well.

—Oliver Wendell Holmes,
Medical Essays.

Nitroglycerin—A Century Later

This is the subject of a fascinating paper published in CMD under the byline of John C. Krantz, Jr., Ph. D., Professor Emeritus of Pharmacology, University of Maryland School of Medicine. He begins it this way:

"The disease angina pectoris was described in 1708 by Heberden before the Royal College of Physicians. It is interesting to quote his comment on the malady:

" 'They who are afflicted with it are seized while they are walking (more especially if it be uphill, and soon after eating), with a painful and most disagreeable sensation in the breast which seems as if it would extinguish life, if it were to increase or continue; but the moment they stand still, all of this uneasiness vanishes.'

"A century later, the distinguished English therapist Lauder Brunton suggested the use of the first valuable drug, amyl nitrite, in the treatment of coronary insufficiency. This was to be followed in 12 years by Murrell's suggestion of the use of nitroglycerin in the disease. Almost a century later, this same drug remains as the sheet anchor in the treatment of coronary insufficiency."

Dr. Krantz concludes his paper with the observation that:

"The fact that nitroglycerin, the active ingredient in dynamite, dilates the coronary vessels at present remains an enigma enveloped in an inscrutable puzzle."

Shoe's On The Other Foot!

Asks Hubert A. Ritter, M. D., president of the St. Louis Medical Society: "Wouldn't it be wonderful if the television news commentators could get as upset over government invasion of private medical practice as they have about Vice-President Agnew's invasion of their private domain? Unfortunately, these same commentators are the very first to want our profession hamstrung."



othing
relief for
air-raising
cough

Benylin®
EXPECTORANT

Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride), Parke-Davis; 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol. An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT *is the leading cough preparation of its kind.* BENYLIN EXPECTORANT *tends to inhibit cough reflex ...soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes* BENYLIN EXPECTORANT *easy to take.*

PRECAUTIONS: *Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with* BENYLIN EXPECTORANT *should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing* BENYLIN EXPECTORANT.

ADVERSE REACTIONS: *Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.*

PACKAGING: *Bottles of 4 oz., 16 oz., and 1 gal.*

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

50669

lubadub lubadub

His heart tells him he's an invalid.
You know he's not.



Photograph professionally posed.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

badubdub lubadu

xiety is expected in the cardiovascular patient.
ttle may even be desirable.

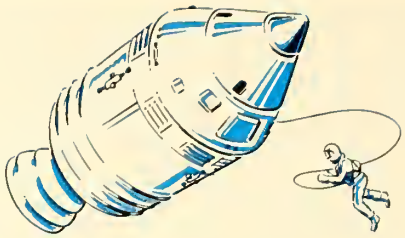
when anxiety is exaggerated . . . when it
erferes with sleep . . . when it aggravates
diovascular symptoms, your help may
needed.

turally, you'll want to reassure the patient.

d perhaps prescribe Equanil (meprobamate)
adjunctive therapy. It helps relieve anxiety
d tension specifically, yet gently.

most 15 years' use has shown that Equanil
usually well tolerated as well as effective.
e effects are generally limited to transient
wsiness; serious, therapy-interrupting
e effects are rare.

Equanil®
(meprobamate) Wyeth®



Man in space, naw fait accampli, re-emphasizes the importance of Ura-Phasphate therapy. Research inta the effect of space travel on the astranaut reveals that weightlessness causes lass af bane calcium. As the bones are required ta bear less and less af the weight of the bady they lase calcium, increasing the calcium cantent af the urine. When physical activity is reduced, the acidity af the urine shauld be adjusted to keep increased calcium in salution . . . . a praphylaxis to prevent kidney ar bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet cantains: METHENAMINE, *300 mg.;* SODIUM ACID PHOSPHATE, *500 mg.*

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

Far pratectian af the inactive patient 1 ar 2 tablets every 4 ta 6 haurs is usually sufficient ta keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing ta camfart and rest.

A clinical supply will be sent ta physicians and haspitals an request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals

Alabama Department of Public Health

BUREAU OF PREVENTABLE DISEASES

Frederick S. Wolf, M. D., Director

Current Morbidity Statistics

1969

	Nov.	Dec.	*E. E. Dec.
Tuberculosis	109	76	78
Syphilis	21	33	100
Gonorrhea	537	525	289
Chancroid	1	2	1
Typhoid fever	0	0	0
Salmonella	36	12	4
Undulant fever	0	0	0
Shigella	12	2	9
Amebic dysentery	1	2	2
Scarlet fever & strep. throat	1,093	777	297
Diphtheria	0	0	4
Whooping cough	6	5	4
Meningitis	19	5	8
Tularemia	0	0	0
Tetanus	0	2	1
Poliomyelitis	0	0	0
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	4	2	18
German Measles	7	7	3
Chickenpox	20	73	38
Mumps	26	23	21
Infectious hepatitis	51	35	36
Typhus fever	0	0	0
Rocky Mt. spotted fever	1	0	0
Malaria	3	0	0
Cancer	1,415	471	606
Rheumatic fever	14	2	13
Rheumatic heart	15	18	23
Influenza	181	89	150
Pneumonia	352	273	256
Rabies-Human cases	0	0	0
Pos. animal heads	0	3	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

Foot-in-Mouth Disease

The young student nurse was about to begin her first day in a hospital. Remembering the advice of the Head Nurse, she had resolved to encourage patients. Seeing an elderly man who was sitting up in bed she greeted him cheerfully and said, "Well, you don't look like you'll be with us much longer."

—Capsuled Comments

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

Laboratory Combined Division All Report for Period December 1969

	No. Specimens Received
General Bacteriology	1,936
Virology	262
Parasitology	1,408
Enteric Bacteriology	298
Fluorescent Microscopy	4,826
Tuberculosis	4,982
Mycology	64
Milk and Dairy Products	5,168
Water	3,491
Sea Foods	122
Syphilis Serology	27,823
Special Serology	1,178
Metabolic Diseases	29,931
Cytology	2,479
Chemistries	197
Miscellaneous	772
Total Number of Specimens Received	84,937

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

Laboratory Combined Division All Report for Period September, 1969

	No. Specimens Received
General Bacteriology	2,135
Virology	288
Parasitology	1,749
Enteric Bacteriology	398
Fluorescent Microscopy	4,324
Tuberculosis	4,468
Mycology	97
Milk and Dairy Products	5,600
Water	3,640
Sea Foods	107
Syphilis Serology	40,726
Special Serology	1,318
Metabolic Diseases	29,591
Cytology	2,314
Chemistries	179
Miscellaneous	793
Total Number of Specimens Received	97,772

Huge TVA Nuclear Power Plant Checked For Pollution

The largest nuclear power plant in the world is being constructed by the Tennessee Valley Authority in Limestone County. Scheduled to begin producing electricity late in 1971, the $500 million plant at Browns Ferry will operate under the watchful eye of state health department physicists.

A nuclear power plant has the potential for contaminating the environment with radioactivity, points out William T. Willis, director of the Division of Radiological Health. Elaborate precautions are being taken, however, by the state health department and TVA to minimize this possibility.

The Browns Ferry power plant is located in a rural area about 10 miles from the nearest municipalities —Athens and Decatur. The total plant capacity of the three-unit complex is nearly 3.5 million kilowatts, almost twice the capacity of any power plant now operating in the United States. Only the first generating unit is scheduled for operation in 1971.



PHOTO 1—Low level radioactive gases will be discharged from this 600 ft. stack, still under construction, at the Browns Ferry nuclear power plant.

The State Health Department has two responsibilities in regard to the power plant: (1) conducting an off-site environmental surveillance program and (2) developing an emergency plan.

An environmental surveillance program has been in progress in the Browns Ferry area for several months for the purpose of establishing "normal" levels of radioactivity. Data collected before the plant begins operating will be compared with data collected afterward in a continuous surveillance program.

Water, milk, and air samples are collected routinely each month and analyzed in the radiological health laboratory of the state health department. About once every six months additional samples are taken from near the plant site—river sediment, fish from the Tennessee River, soil and vegetation from farms along the river.

Four water sampling stations and seven air sampling stations are located in the Browns Ferry area. Water sampling stations are at Decatur, above the plant site, and Sheffield, below the plant site; on Limestone Creek, near Athens; and on Elk River, the municipal water source for Athens. The air sampling devices are located at strategic points in the immediate area surrounding the plant site. Three are controlled by wind direction.

A new testing method—theromoluminescence dosimetry (TLD)—is being tried also. About 10 dosimeters have been placed in the Tennessee Valley area. This test is conducted on the principle that certain materials, after exposure to radiation, will give off light proportional to the radiation exposure.

Radioactive wastes are released inevitably and, in most cases, harmlessly from nuclear power plants, points out Lloyd G. Linn Jr., head of the radiological health laboratory. There will be a continuous emission of low level radioactive gases from the 600 ft. stack at the Browns Ferry plant. And there will be a small amount of low level liquid wastes which will be discharged to the Tennessee

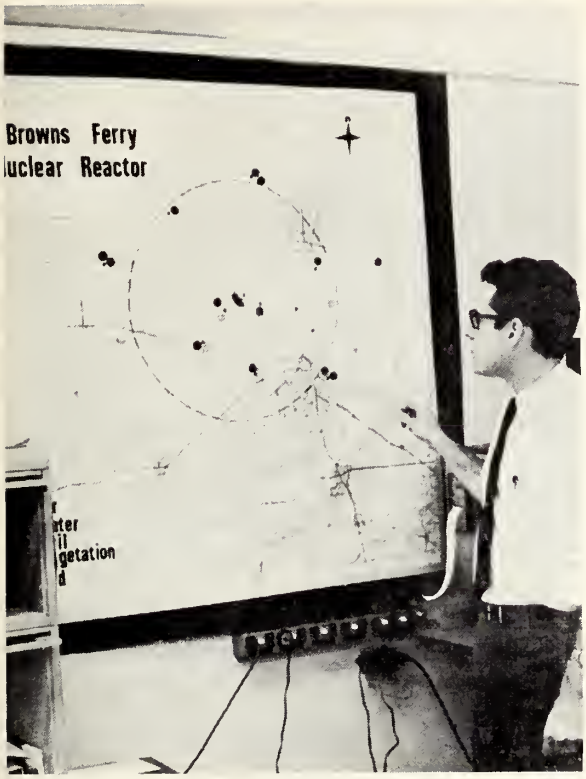


PHOTO #2—Lloyd G. Linn, Jr., head of the radiological health laboratory, points out the sites of water and air sampling stations in the Browns Ferry area.



PHOTO #3—Samples of milk, air, and corn are prepared for beta counting in the radiological health laboratory.

River. Any waste with significant levels of radioactivity will be treated to remove the radioactive material before it is discharged to the environment. Conceivably, however, radioactive contaminants could build up to a harmful level in the environment. The state health department's monitoring system would detect such a buildup before it reached the critical stage.

Infants are at highest risk of over-exposure to radiation. Radioactive iodine found in milk would be concentrated in the infant's thyroid gland. The infant is at high risk because his diet consists almost entirely of milk for several months, and radioactive iodine which concentrates in the thyroid could damage the child's thyroid gland.

In addition to the environmental surveillance program, the state health department is responsible for developing an emergency plan for coping with a nuclear "accident." Should engineering safeguards built into the plant fail, a large amount of radioactivity could be released. In this event it might be necessary to evacuate the area, remove milk from the market, or quarantine cattle. A detailed plan is being developed.

Among the approximately 20 nuclear power plants operating in the United States, none has ever discharged a harmful amount of radioactive waste into the atmosphere. There have been cases of malfunction, Mr. Willis related, but engineering safeguards were sufficent to control leakage. Several years ago in England a gas reactor (TVA's are boiling water reactors) contaminated the countryside, forcing the evacuation of nearby residents. However, no one was injured in the incident.

The plant at Browns Ferry is being constructed with "built-in" safeguards. The reactor vessel is encased in a steel tank, and



PHOTO #4—A Low-Beta counter is used to monitor environmental samples.

the tank is enclosed by a concrete shield. The building itself is a containment vessel. TVA will have a network of alarms and monitors to detect the slightest malfunction.

TVA is also conducting an environmental surveillance program, the results of which are correlated with the state health department's data. In addition to conducting tests similar to those of the health department's, TVA has also made a long range study of wind direction. For example, TVA found that the wind blows in a northwesterly direction 75 per cent of the time.

The Alabama Power Company has been given approval by the Alabama Public Service Commission to construct a nuclear power plant on the Chattahoochee River near Dothan where similar safeguards to protect the environment will be instituted.

Within the next few years, nuclear electricity will be lighting homes and turning machinery in both north and south Alabama.

BUREAU OF VITAL STATISTICS

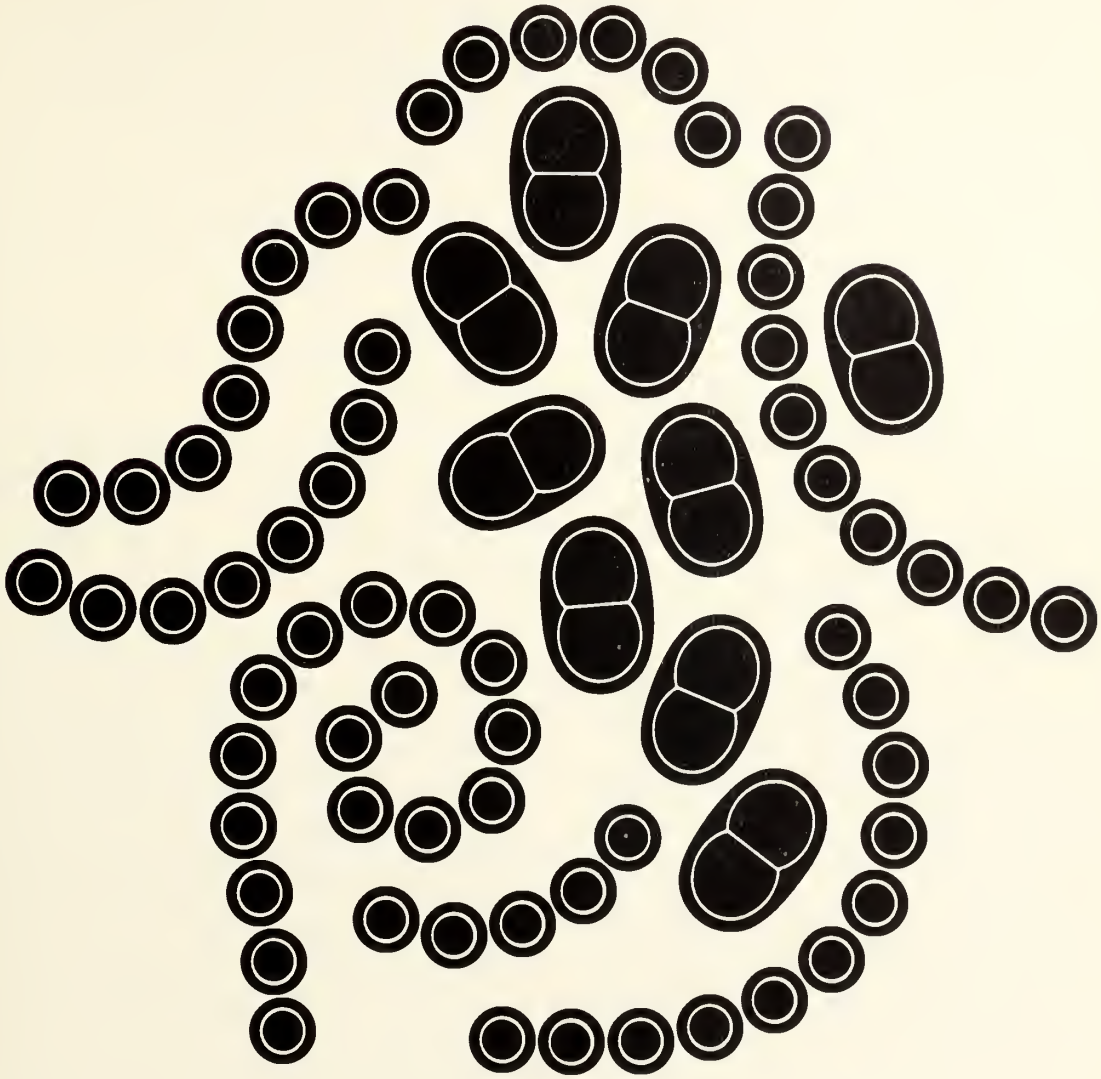
PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA

Ralph W. Roberts, M. S., Director

November 1969

Live Births Deaths Causes of Death	Number Recorded During November, 1969			Rates* (Annual Basis)		
	Total	White	Non-White	1969	1968	1967
Live Births	5,260	3,488	1,772	17.6	17.3	17.7
Deaths	2,865	1,949	916	9.6	8.7	9.1
Fetal Deaths	113	44	69	21.0	20.0	20.4
Infant Deaths—						
under one month	119	65	54	22.6	21.8	20.7
under one year	158	82	76	30.0	29.6	30.7
Maternal Deaths	2	.....	2	3.7	5.8	.....
Causes of Death						
Bacillary dysentery, amebiasis, 004, 006	.....	.....	.....	.....	0.3	.....
Enteritis, other diarrheal diseases, 008, 009	7	4	3	2.3	†	†
Tuberculosis, all forms, 010, 019	19	6	13	6.3	3.0	5.8
Diphtheria, 032	.....	.....	.....	.....	.....	0.7
Whooping Cough, 033	.....	.....	.....	.....	.....	.....
Meningococcal infections, 036	.....	.....	.....	.....	.....	0.3
Poliomyelitis (acute), 040-043**	.....	.....	.....	.....	.....	0.3
Measles, 055	.....	.....	.....	.....	.....	.....
Syphilis, 090-097	1	1	.....	0.3	1.0	1.4
Malignant Neoplasms, 140-209	429	328	101	143.2	128.6	128.4
Diabetes Mellitus, 250	44	30	14	14.7	18.6	18.1
Major cardiovascular diseases, 390-448	1,439	1,016	423	480.3	†	†
Diseases of heart 390-398, 402, 404, 410-429	919	669	250	360.7	303.6	304.3
Rheumatic fever & heart, 390-398	14	9	5	4.7	†	†
Hypertensive heart & renal diseases, 402, 404	27	15	12	9.0	†	†
Ischemic heart disease, 410-414	785	580	205	262.0	†	†
Cerebrovascular disease, 430-438	418	277	141	139.5	103.6	125.7
Diseases of the arteries, 440-448	87	66	21	29.0	15.9	24.6
Influenza, 470-474	2	1	1	0.7	0.3	1.4
Pneumonia, 480-486	89	49	40	29.7	17.9	24.9
Bronchitis, emphysema, asthma, 490-493	43	34	9	14.4	†	†
Appendicitis, 540-543	4	.....	4	1.3	1.0	0.3
Hernia, intestinal obstr., 550-553, 560	7	5	2	2.3	3.4	3.1
Cirrhosis of liver, 571	20	15	5	6.7	7.1	5.5
Complications of preg., childbirth, 630-678	2	.....	2	3.7	5.8	.....
Congenital anomalies, 740-759	24	18	6	4.6	4.1	6.0
Immaturity, 777	21	8	13	4.0	6.5	6.0
Accidents, total, 800-949	183	130	53	61.1	75.8	70.7
Motor vehicle accidents, 810-823, 940	102	76	26	34.0	47.4	38.2
All other defined causes	367	238	129	122.5	114.1	122.9
Symptoms & ill-defined, 780-796	164	66	98	54.7	46.7	47.8

during and after infection



Berocca®

TABLETS
high potency B-complex and C
for nutritional support

AVAILABLE ONLY ON Rx

contains water-soluble vitamins only

b.i.d. dosage

good patient acceptance

no odor, and virtually no aftertaste

Each Berocca Tablet contains:

Thiamine mononitrate	15 mg
Riboflavin	15 mg
Pyridoxine HCl	5 mg
Niacinamide	100 mg
Calcium pantothenate	20 mg
Cyanocobalamin	5 mcg
Folic acid	0.5 mg
Ascorbic acid	500 mg

Usual dosage is one tablet b.i.d.

Indications: Nutritional supplementation in conditions in which water-soluble vitamins are required prophylactically or therapeutically.

Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B_{12}.

Dosage: 1 or 2 tablets daily, as indicated by clinical need.

Available: In bottles of 100.

ROCHE

Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. MASA members having knowledge of practice opportunities or wishing to relocate their own practices are urged to communicate with the Placement Service. For further information: write Mr. Emmett Wyatt, Executive Assistant, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama 36104, or Telephone 263-6441.

Locations Wanted

General Practice—

Age 33, Medical College of Georgia 1968, seeking parttime employment on weekends and holidays relieving a general practitioner or emergency room duties in south Alabama within reasonable commuting distance of Pensacola, Fla. LW-1

Age 38; University of Oklahoma, 1955; seeking associate, institutional or industrial practice; in town of 10,000 plus population; interest in surgery. LW-5

Age 28; University of Tennessee, 1965. LW-7

Age 27, Medical College of South Carolina, 1966; seeking location in Gadsden area or in southern part of state in town of 5-7,000 population; available July 1, 1971. LW-7/1

Age 60, University of Arkansas 1932, seeking location for general or industrial practice. LW-7/3

Age 34; University of Tennessee 1964; seeking associate practice. LW-7/5

Age 29; University of Missouri 1967; National Board, seeking associate or solo practice in city of 50,000 or less population in south Alabama. Available July 1970. LW-7/6

Internal Medicine—

Age 59, Cornell University 1933, American Board certified, seeking group practice. LW-8

Age 31, Medical College of South Carolina 1964, Available July 1970. LW-9

Age 37, Duke University, 1956; Board certified, seeking group, associate, or institutional practice. LW-13

Age 33; University of Miami 1962; Board eligible; National Board; seeking solo, group practice, hospital practice, or industrial practice. LW-13/1

Age 31; Medical College of Georgia 1963; seeking location for practice of internal medicine-cardiology. Available 1970. LW-13/2

Neurology—

Age 32, Medical College of Georgia, 1964, seeking assistant or associate, or institutional practice. LW-14

Age 31; Harvard 1962; Board eligible; National Board; seeking solo, group or associate practice. LW-15

Age 29, Indiana Univ., 1964; Board eligible; seeking assistant or associate practice in city of over 100,000 population. LW-17/1

Obstetrics-Gynecology—

Age 49, University of Nebraska, 1943; Board certified, seeking group or institutional practice. LW-19

Age 34, Medical College of Virginia, 1961, Board eligible, seeking group or associate practice. LW-20

Age 33; University of Illinois, 1964; seeking associate practice. LW-21

Ophthalmology—

Age 33; St. Louis University, 1962; seeking solo, or associate practice. LW-21/1

Otolaryngology—

Age 32, University of Pennsylvania 1962, seeking associate practice. Available April 1970. LW-21/2

Pathology

Age 32, University of Louisville 1966, seeking associate or institutional practice. Available July 1970. LW-21/4

Age 52; New York State University 1940; American Board certified; National Board; seeking institutional practice. Available immediately. LW-21/5

Age 48; George Washington University 1947; National Board, American Board certified; seeking industrial, institutional, or associate practice in Birmingham, Montgomery or north Alabama. LW-21/6

Age 35; University of Miami 1962; Board eligible; seeking solo or associate practice. Available September 1970. LW-21/6

Radiology

Age 28; Northwestern University 1964; completing radiology residency. Available July 1971. LW-24

Age 43; Louisiana State University 1953; Board certified, seeking associate practice, preferably in southern section of state. Available January 1970. LW-24/1

Surgery—

Age 33; University of Missouri, 1961; seeking group or associate practice. LW-27

Age 38; Emory University, 1956; Board eligible, seeking group, associate, or institutional practice. LW-28

Age 36, Indiana University 1961; Board eligible; seeking practice in city of 100,000 plus population. LW-31/1

Age 37, University of Paris 1961; seeking group or institutional practice in city of 80,000 plus population. LW-31/2

Age 48; Marquette University 1943; Board eligible; seeking institutional practice in east Alabama. LW-31/3

Age 31; St. Louis University 1963, American Board certified; seeking associate practice. LW-31/3

Locations Wanted

Age 48; University of Pennsylvania 1950; Board eligible; seeking solo or group practice. LW-31/4

Age 31; Medical College of Alabama 1963; American Board certified; seeking associate practice. Available July 1970. LW-31/4

Age 36, Emory University 1959, Board certified, seeking associate practice. Available September 1970. LW-31/5

Age 31; Medical College of Alabama 1964; National Board. Available July 1971. LW-31/6

Urology—

Age 30; Louisiana State University, 1963; Board eligible, seeking associate, or group practice. LW-32

Age 31, Chicago Medical School 1963, seeking associate practice in Montgomery. Available July 1970. LW-32/1

Student Health—

Age 40, University of Oklahoma 1955, seeking institutional practice. LW-33

Physicians Wanted

Special Openings—

Student Health—additional position has just been authorized. Join staff of seven full time physicians plus mental health, and full laboratory, x-ray, physical therapy and dietary services. Negotiable salary. Excellent fringe benefits. Cultural advantages of University community. PW-18

General surgeon, Board certified, needs young associate to do general practice including obstetrics. Salary negotiable. PW-19

Two physicians, ages 39 and 40, are interviewing for a select individual to enter association in a university town of 80,000 population. Outstanding new physical plant. Readily available hospital privileges. Four and one-half day work week. Three free weekends per month. PW-19/2

Specialist in the following fields: Internal Medicine, Pediatrics, Obstetrics-Gynecology and General Practitioners. 58-bed fully accredited general hospital with 91-bed addition recently completed. Modern new office space available. PW-20

Pediatrician, Internist, and ENT specialist to join a well-established group practice in a community of 40,000 in East Alabama. The community has a 125-bed accredited hospital, 32-bed extended care facility. Good transportation on interstate with quick access to metropolitan area. Will pay travel expense for interview. PW-20-1

Opportunity for ENT, Internal Medicine, and Orthopedic Surgery practitioners to join partnership at clinic located in city of 38,000 population in trade area of 150,000 population in northeast Alabama. PW-20/2

Internists, Board-certified or eligible. One needed now and another in 1 or 2 years. For early partnership with internist in south Alabama city of 40,000 plus population. New office building adjacent to 181-bed hospital. Practice largely hospital in-patient and Cardiology. PW-21

Opportunity for a Board certified or eligible surgeon to be associated with a Board surgeon in city of 150,000 population. PW-21/1

The Alabama Department of Mental Health is seeking several physicians. Vacancies exist at Bryce Hospital, Tuscaloosa, and Searcy Hospital, Mt. Vernon. PW-22

General Practitioner or Internist for associate or separate practice in Birmingham. Modern office space and excellent hospital facilities. PW-26

Position available for a clinic physician with special Family Planning Project of the Jefferson County Department of Health. Salary range $20,000 to $24,000, depending on amount of training in Obstetrics and Gynecology and Family Planning. PW-26/1

Obstetrician-Gynecologist—

Excellent opportunity for a trained Ob-Gyn man, who would join a two-man partnership in city of 30,000 population located in south central Alabama. Salary is proposed for the first year, with partnership thereafter. PW-25

General Practitioners—

For town of 2,000 population located in trade area of 15,000 population in northeast Alabama. Nearest metropolitan centers 30 miles distance. Industrial area. Clinic and some office equipment available. Several churches, schools, and civic clubs. PW-23

Opportunity for GP to join well established four-man partnership; three general practitioners and one board certified surgeon. Practice located in city of 8,000 population, trade area of 60,000, north-central Alabama. Modern new partnership-owned offices adjacent to modern 125-bed fully accredited hospital. Salaried first year with possible partnership status at end of first year. PW-27

Opportunity in town of 4,000 population in trade area of 50,000 population, located within 100 miles of two metropolitan areas in south Alabama. Industrial and farming area. 44-bed hospital. Office space and equipment available in new building with another physician. Several churches, schools, and service clubs. PW-1

For community of 1,500 population located in south Alabama near city of 12,000 population. Hospitals located within 25 miles. Office space and equipment available. Farming, cattle and textile industries in the area. Several churches and school. Civic clubs and golf courses. PW-1-1

For town of 10,000 population in county of 40,000 population located in scenic mountainous section of Northeast Alabama. Office space and equipment available. Hill-Burton hospital-nursing home. Expanding industries in top agricultural area. PW-1-2

For community of 2,000 population, plus large trade area, located in Southeast Alabama. Modern clinic, fully equipped. PW-1-3

(Continued on Page 882)

Physicians Wanted

(Continued from Page 881)

Opportunity in port town of 1,000 plus population in population center of 10,000 located in Southeast Alabama. Clinic available. Hospital located less than 20 miles away. Recreational advantages for water sports. Expanding industrial and farming area. Churches and schools. PW-1-4

For town of approximately 1,000 population in Northwest Alabama, near Tennessee Valley waterways. New 15-bed clinic available. Centrally located near metropolitan areas. Extensive industrial developments. PW-1-5

For town of 12,500 population in trade area of 50,000 located in South Alabama. Nearest large city with population of 145,000 is 80 miles away. Two hospitals with 140 beds. Numerous small industries. Several churches and schools. Recreational activities include water sports and golf course. PW-1-6

General Practitioner to join partnership in town of 3,000 population, plus trade area of 20,000 population in northwest Alabama. Modern office building with six examining rooms. Full partnership at beginning of third year. New 30-bed Hill-Burton hospital. Salary open. PW-1/7

Opportunity in community of 3,000 population with over 8,000 population in trade area, near metropolitan area in northwest Alabama. Clinic and office equipment available. New 400-bed hospital and older hospital, and several nursing homes. PW-1/8

For town of 2,000 population in trade area of 7,000 population located in west Alabama. Physician recently died. Nearest city is 30 miles away. Medical facilities include Hill-Burton hospital and nursing home. Churches, schools, civic clubs, and recreational advantages. PW-1/9

For town of 1,800 population located in southeast Alabama in a population center of 10,000 population. PW-1/10

For town of 7,000 population located in population center of 15,000 population located in northeast Alabama. Office space and equipment available. Hospitals located in adjoining towns within 12 miles. State University located in the town. PW-1/11

For town of 2,500 population located in northeast Alabama. 17-room modern brick clinic fully equipped. Hospital nearby. Excellent schools and recreational advantages, water sports. PW-1/12

For town of 5,000 population, located in northwest Alabama. 55-bed hospital being completely renovated, and an adjoining 69-bed nursing home. PW-1/13

Opportunity in well situated central Alabama county, trade area of 18,000 population, manufacturing, mining, farming region. New office building furnished. 33-bed accredited hospital. Excellent recreational facilities including new country club. PW-1/14

Opportunity for group practice in town of 10,000 population in north Alabama. PW-2

Physician wanted to join 39 year old Medical College of Alabama graduate in a well established general practice in West Central Alabama town. Salary initially followed soon by full partnership. PW-3

Opportunity in community of 2,500 population in trade area of 8,000 population located 20 miles from metropolitan center in north Alabama. Proposed medical center development. PW-4

Physician wanted to join well established partnership in Northwest Alabama city of 15,000 population. Two accredited hospitals, junior college, schools, churches, recreational activities. No obstetrics or surgery. New office building. PW-7

For city of approximately 15,000 population in north Alabama, with trade area of approximately 45,000 population. Hospital with over 100 beds, and expansion planned for next year. Nursing homes in the area. Industrial growth and agricultural region. Several churches and schools. Golf course, civic and fraternal organizations. PW-8

For city of 5,000 population located 80 miles northwest of Birmingham. Industrial area. JCAH certified hospital facilities of 70 beds. Office space available for $200 per month. Guaranteed income. One physician in city desires partner, no investment, or associate. PW-1/15

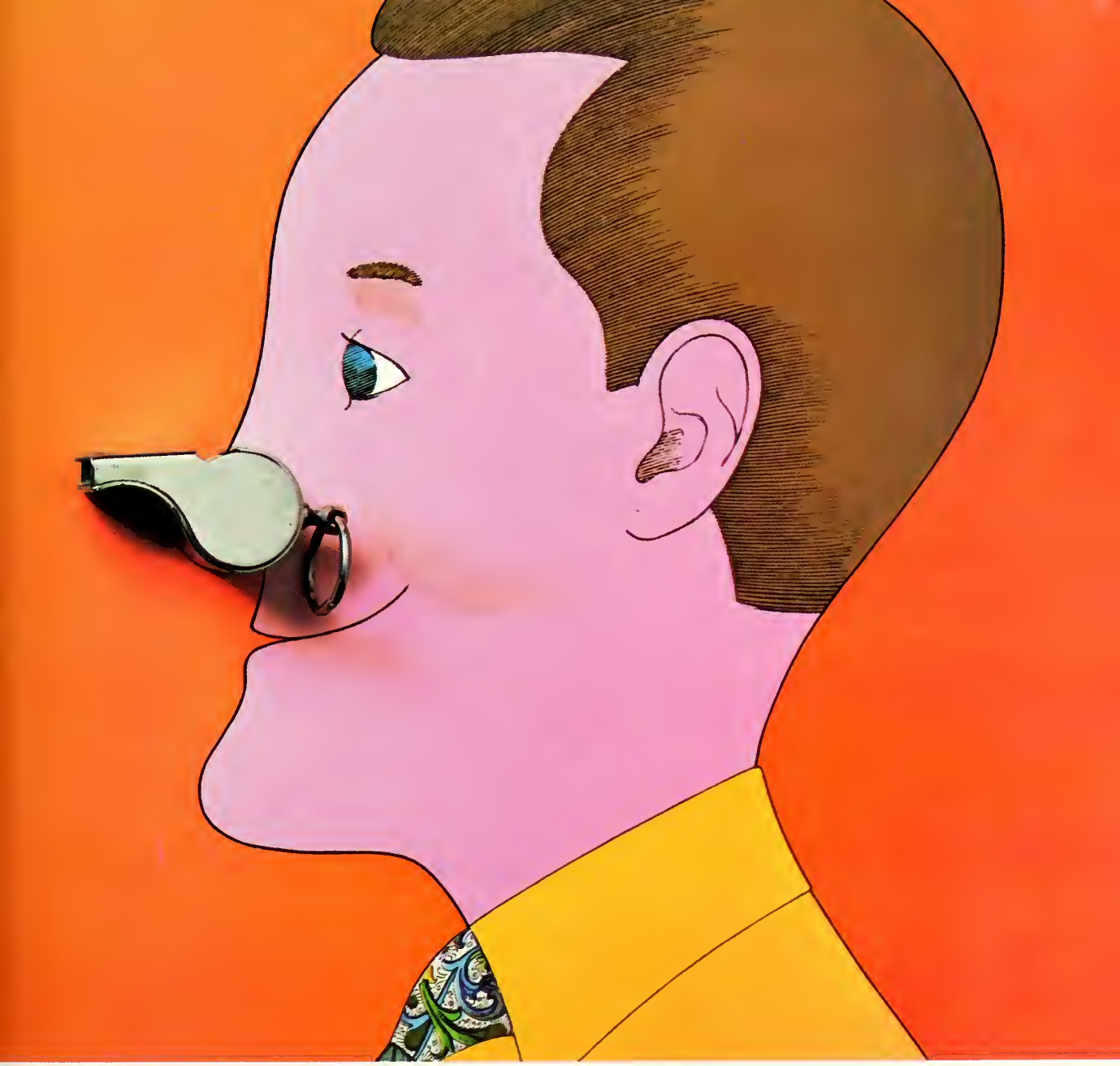
For community of 2,000 population located in central Alabama, 30 miles southeast of Birmingham. Farming area. Clinic available. PW-1/16

For town of 3,600 population in trade area of 5,000-7,000 within 100 miles of two large cities and the Gulf Coast. 50-bed hospital located in the town. Office space available. Agricultural and expanding industrial area. Several churches and two schools. Recreational activities in the town as well as nearby—golf course, hunting and fishing. PW-17

Unusual opportunity for two general practitioners with military obligations satisfied at a modern fifty bed facility located 15 minutes drive from largest metropolitan center in north-central Alabama. Construction of a new two-story office building is scheduled to begin soon. PW-18

Opportunity in city of 5,000 population located in Northeast Alabama in trade area of approximately 10,000 population. Office space available. One physician died recently. Hospital and nursing home in the city. PW-19

Hospital based professional association in suburb of Birmingham is seeking a young general practitioner who has completed military obligation. High income, profit sharing, paid vacation and retirement plan. Complete facilities available. No investment required. PW-19/1



Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS

Hasn't the driver had enough excitement for one day?

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.



Driver Escapes Serious Injury When Truck Jackknifes

SHENANDOAH, JULY 16. Roger Sherman of Waynesboro suffered head lacerations but escaped serious injury when the tractor-trailer he was driving skidded on Deep Run Bridge and jackknifed. It took reseue workers thirty minutes to remove him from the cab which was dangling over the edge of the bridge. Sherman is resting comfortably in University Hospital where his condition is listed as satisfactory.

Frankhouser called my attenti

Phenaphen® with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg. Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg. Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

A. H. Robins Company, Richmond, Va. 23220 A·H·ROBINS

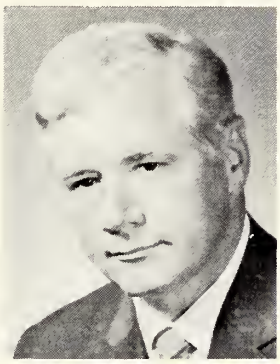


ALAPAC Luncheon Speakers

"Everyone ought to be a senator once in his lifetime," a Florida doctor wrote in a recent issue of *Medical Opinion and Review*, a New York magazine circulated widely in the profession. The author is John J. Fisher, M. D., of Jacksonville, who served two terms in the Florida House of Representatives and now plans to seek a state senate seat.

A State Senator from South Dakota, an M. D. who has been involved politically in his home state for the better part of a decade and who is expected to be the Republican nominee for Governor in 1972, will be one of the two speakers at the ALAPAC luncheon in Mobile on Friday, May 1st, in the midst of MASA's annual meeting.

The Speaker of the House of the Indiana Legislature, an M. D. who has been involved politically for about the same length of time, and who is considered a very likely candidate for Governor on the Republican ticket in 1972, will be the other ALAPAC luncheon speaker scheduled for this time.



DR. BARTRON



DR. BOWEN

The two are: G. Robert Bartron, M. D., surgeon and chief of staff of the Bartron Hospital and Clinic, Watertown, South Dakota, and Otis R. Bowen, M. D., in general practice in Bremen, Ind.

Dr. S. Buford Word, President-elect of the Medical Association of the State of Alabama, plans to feature one of them on his orientation program Thursday morning, April 30th, if the visitor's schedule can be adjusted to take care of it.

On ALAPAC Board

The newest member of the ALAPAC Board of Directors is an ophthalmologist from Dothan, Louis Lanier Johnson, M. D. He is the board member representing the 3rd Congressional District.

Dr. Johnson was born in Grove Hill, graduated from Eufaula High School, earned his B. S. from Auburn in 1949, and his M. D. from Alabama four years later.

Interned at Oak Knoll Naval Hospital, he attended the U. S. Naval School of Aviation Medicine, later serving as Flight Surgeon at the Navy's Corry Field, Pensacola.

Dr. Johnson attended the Lancaster Course in Ophthalmology at Colby College, Waterville, Maine, and subsequently served a residency at the Massachusetts Eye and Ear Infirmary, Boston. Certified by the American Board of Ophthalmology, he began practice in Dothan in July, 1960, and has since served two consecutive terms as president of the Alabama Academy of Ophthalmology and Otolaryngology.

Dr. Johnson is married to the former Ola Freeman of Birmingham and they have one son, Mark Lanier, age 15.

For almost a quarter of a century, Dr. Johnson's principal hobby interest has been work with the Boy Scouts.

INDEX TO ADVERTISERS

Arch Laboratories 817

The Bradley Center 864
Blue Cross-Blue Shield 869
Breon Laboratories 813
Burroughs Wellcome & Co. 816

Campbell Soup 841

Guest House Motel 852

Highland Hospital 818
Hynson, Westcott & Dunning 805

Lederle Laboratories 807, 815, 886
Eli Lilly & Company ..... 1st Cover, 830

Wm. S. Merrell Co. ..... 3rd Cover
Merck, Sharp & Dohme 822, 823, 824

National Drug Company ..... 2nd Cover, 861, 862

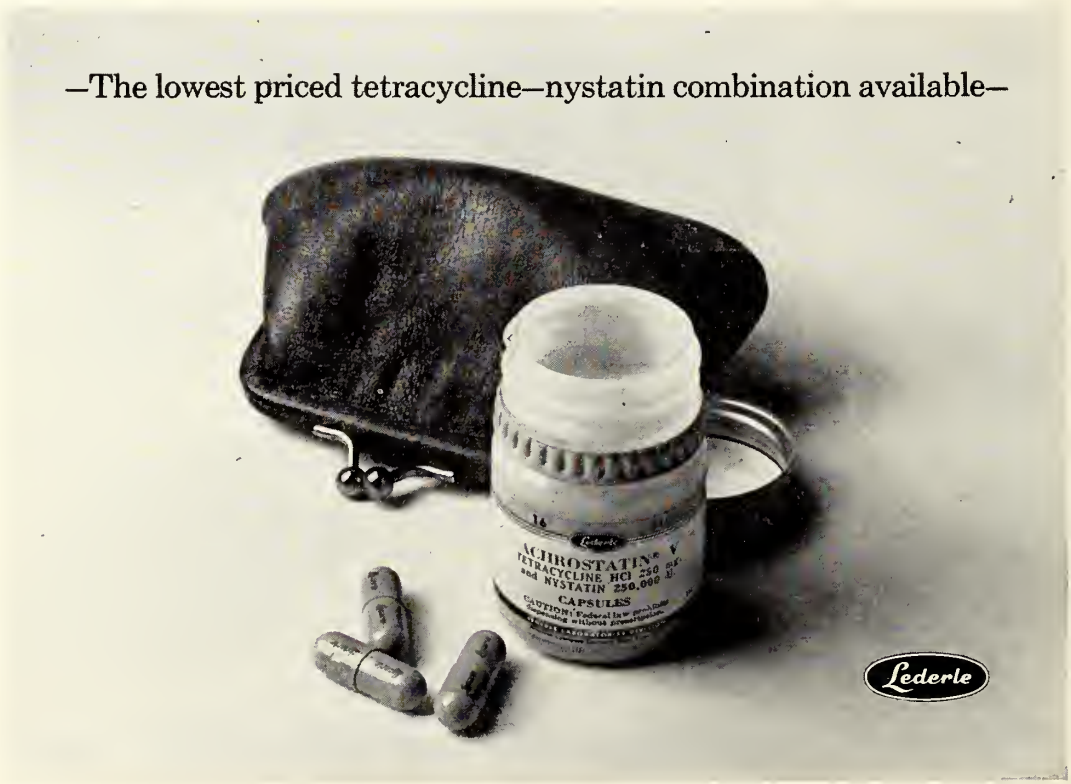
Parke Davis & Co. 844, 871
Wm. P. Poythress & Co., Inc. 874

A. H. Robins Company 849, 883, 884
Roche Laboratories ..... 828, 879, 4th Cover

G. D. Searle & Co. 842, 843
Stuart Company 853

Wyeth Laboratories 872, 873

—The lowest priced tetracycline—nystatin combination available—



Can one prescription do the work of two?

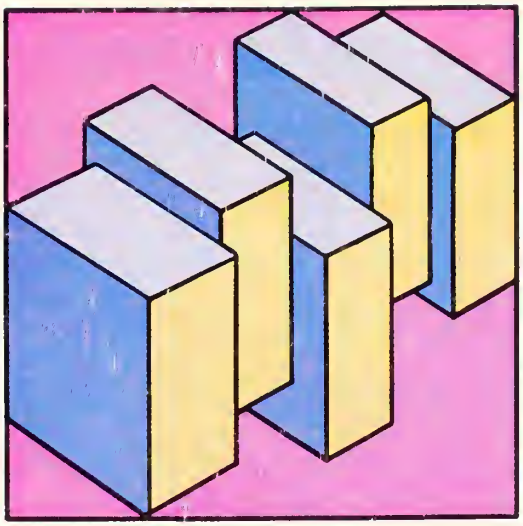


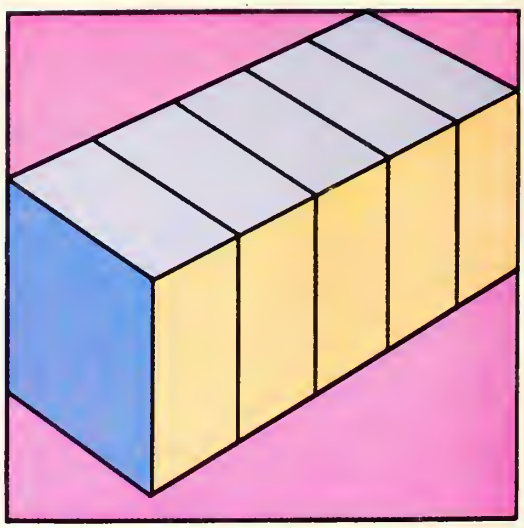
Yes, Kolantyl®

Kolantyl Gel/Wafers contain antacids, and Bentyl® (dicyclomine hydrochloride) too.

Merrell

The Wm. S. Merrell Company
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215





from the discord of anxiety...

to emotional harmony

Before prescribing, please consult complete product information, a summary of which follows:

INDICATIONS: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.
CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.
WARNINGS: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
PRECAUTIONS: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
ADVERSE REACTIONS: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido--all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

with the aid of antianxiety

Librium®
(chlordiazepoxide HCl)
5-mg, 10-mg and 25-mg capsules

In an age of swift change and challenge, susceptible individuals may experience varying degrees of excessive anxiety. The resulting emotional stress may precipitate significant functional disorders or complicate existing organic disease. In properly individualized maintenance dosage, Librium (chlordiazepoxide HCl) quickly helps relieve anxiety and apprehension, provides useful adjunctive therapy in psychophysiologic disorders. In long clinical experience, Librium has demonstrated a wide margin of safety.

Also available:
Libritabs®
(chlordiazepoxide)

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

CONVENTION PROGRAM ISSUE

JOURNAL of the Medical Association of the State of ALABAMA



THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON

29 APR 1970

IN THIS ISSUE

Program of the 109th Annual Session of MASA 904
Peripheral Vascular Injuries 913
The Use of Locorten Cream in the Treatment of Common Dermatoses . . . 919
Pulmonary Function Testing for the General Hospital and Physician (Part V) 922



Change Office
Francis A. Countway Lib. of
Medicine
10 Shattuck St.
Boston, Massachusetts 02115

APRIL 1970

The girth control pill



Tepanil® Ten-tab®
(continuous release form)

(diethylpropion hydrochloride)

works on the appetite not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Controindicotions: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionolly unstable potients susceptible to drug abuse.

Worning: Although generally safer than the amphetamines, use with great caution in potients with severe hypertension or severe cardiovosculor disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reoctions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride hove been reported to occur in relotiveiy low incidence. As is charocteristic of sympathomimetic agents, it may occasionolly couse CNS effects such os insomnia, nervousness, dizziness, onxiety, ond jitteriness. In controst, CNS depression has been reported. In a few epilep on increase in convulsive episodes has been reported. Sympathomimetic car vascular effects reported include ones such as tachycardia, precordial p arrhythmia, palpitotion, ond increased blood pressure. One published re described T-wave changes in the ECG of a healthy young mole after ingestio diethylpropion hydrochloride; this was an isolated experience, which has not b reported by others. Allergic phenomena reported include such conditions as r urticaria, ecchymosis, and erythemo. Gastrointestinal effects such as diarrh constipation, nausea, vomiting, ond obdominal discomfort have been repor Specific reports on the hematopoietic system include two each of bone mar depression, ogranulocytosis, and leukopenia. A variety of miscellaneous adv reactions have been reported by physicians. These include complaints such as mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decrec libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. ta daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet th times daily, one hour before meals. If desired, an additional tablet may be give midevening to overcome night hunger. Use in children under 12 years of age is recommended.

T-006A / 1/70 / U.S. PATENT NO. 3,001

THE NATIONAL DRUG COMPA
DIVISION OF RICHARDSON-MERRELL I
PHILADELPHIA, PENNSYLVANIA 191

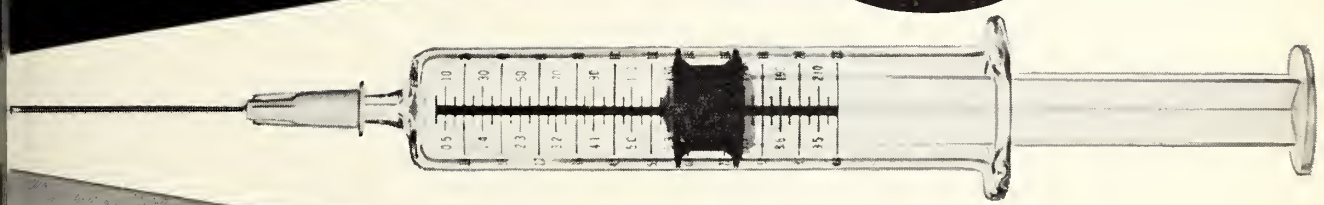
BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

MEDICINE
BOSTON
R 1970

BSP®



BROMSULPHALEIN® IN A STERILE, DISPOSABLE, ECONOMICAL UNIT

The Bromsulphalein test is a convenient, sensitive, reliable test of liver function.

The precalibrated syringe contained in the BSP Disposable Unit makes weight calculations unnecessary, providing proper dosage regardless of patient-weight. Each unit contains complete directions for use, precautions and contraindications.

The all-inclusive BSP Disposable Unit provides economic unit dispensing.

Complete literature available on request.

HYNSON, WESTCOTT & DUNNING, INC.

HW&D

Baltimore, Maryland 21201

(BSP04)

THE JOURNAL

of the

Medical Association of the State of Alabama

Volume 39 • April, 1970 • No. 10

Office of Publication
19 So. Jackson St. .... Montgomery, Ala. 36104
Subscription Price ..... $5.00 Per Year
$1.00 Per Copy

Second Class Postage Paid at Montgomery, Alabama. Published monthly in Montgomery at 19 South Jackson Street.

Editor-in-Chief
William L. Smith, M. D. ..... Montgomery

Managing Editor
L. P. Patterson ..... Montgomery

Assistant Managing Editor
Mary Nell Williford ..... Montgomery

Associate Editors
J. P. Collier, M. D. ..... Tuscaloosa
John M. Chenault, M. D. ..... Decatur
M. Vaun Adams, M. D. ..... Mobile

Officers of the Association

President
C. Kermit Pitt, M. D. ..... Decatur

President-Elect
S. Buford Word, M. D. ..... Birmingham

Vice-Presidents
F. M. Phillippi, Jr., M. D. ..... Brewton
J. E. Cameron, M. D. ..... Alexander City
O. Emfinger, M. D. ..... Union Springs
Wood S. Herren, M. D. ..... Birmingham

Secretary-Treasurer
William L. Smith, M. D. ..... Montgomery

Executive Director
L. P. Patterson ..... Montgomery

The State Board of Censors
John M. Chenault, M. D., Chmn. ..... Decatur
J. P. Collier, M. D. ..... Tuscaloosa
Hugh E. Gray, M. D. ..... Anniston
Paul W. Burleson, M. D. ..... Birmingham
L. L. Hill, M. D. ..... Montgomery
M. Vaun Adams, M. D. ..... Mobile
J. D. Bush, M. D. ..... Gadsden
E. L. Strandell, M. D. ..... Brewton
John W. Davis, Jr., M. D. ..... Montgomery
J. Garber Galbraith, M. D. ..... Birmingham

State Health Officer
Ira L. Myers, M. D. ..... Montgomery

Delegates and Alternates to the American Medical Association

(Terms expiring December 31 of year shown.)

1970
Delegate—E. Bryce Robinson, Jr., M. D., ... Fairfield
Alternate—W. E. White ..... Anniston

1971
Delegate—M. Vaun Adams, M. D. ..... Mobile
Alternate—E. L. McCafferty, Jr., M. D. ..... Mobile
Delegate—P. W. Burleson, M. D. ..... Birmingham
Alternate—Robert Parker, M. D. ..... Montgomery

CONTENTS

President's Page 890

The Woman's Auxiliary 891

Editorial Comment 898

Massachusetts Doctors Attack Secret-Inquest Decision 898

Question of Morality Raised in Organ Donation 900

Old Venereal Disease Fire Horse Hears The Bell Clang Again 902

A Month For Monuments For Medicine 903

Program Of The 109th Annual Session Of MASA 904

Scientific Section 913

Peripheral Vascular Injuries, Henry L. Laws, M. D., Anniston 913

"The Use Of Locorten (Flumethasone Pivalate) Cream In The Treatment Of Common Dermatoses," Paul G. Reque, M. D., and Robert O. Lauderdale, M. D., Birmingham 919

Pulmonary Function Testing For The General Hospital And Physician, Part V, D. S. Tysinger, Jr., M. D., Dothan 922

Hobbies To Fill A Doctor's Leisure 933

Physicians In Pursuit Of Postage Stamps 933

The Month In Washington 937

Association Forum 945

Tubal Ligation And Abortion In the State of Alabama, Charles E. Flowers, Jr., M. D., Birmingham 945

Fathers And Sons In Medicine 953

Seven Stablers Have Or Will Practice In Greenville 953

Two Of Jordan Medical Trio In Birmingham, One In Atlanta 956

Around The State 959

Vital Statistics 959

County Medical Society Officers For 1970 Announced 964

Legal Page 970

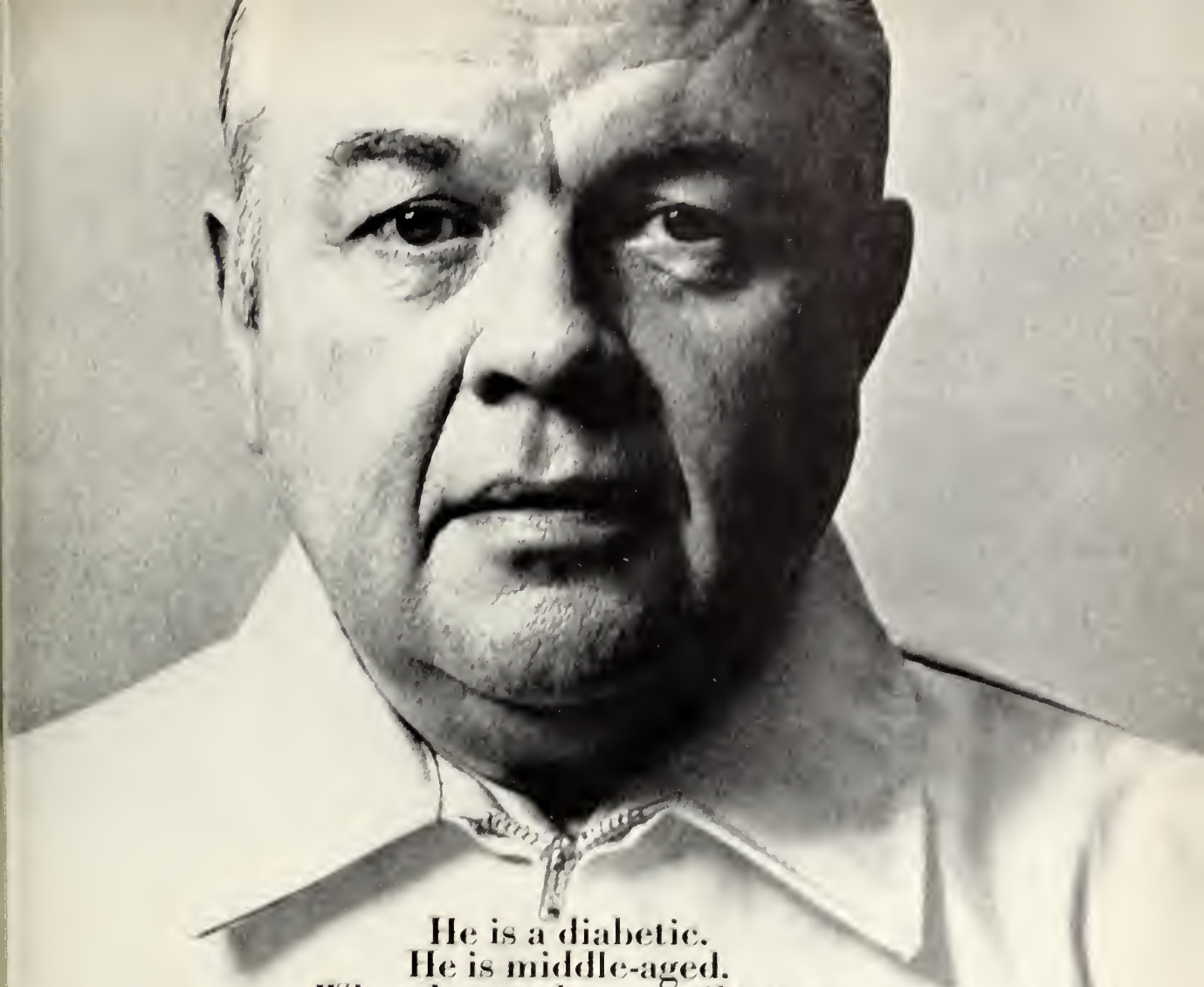
Medical Malpractice Patient Vs. Physician 970

How To Avoid Malpractice Suits 970

Safety In Flying Lies In More Flying, A Flying Doctor Declares 972

Alabama Department Of Public Health 973

Registered Nurse Utilization—A Key To Improved Patient Care 973



He is a diabetic.
He is middle-aged.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

guard susceptible patients against intestinal monilial overwth during broad-spectrum therapy—the protection of tatin is combined with demethylchlortetracycline in CLOSTATIN.

or your susceptible candidates, prescribe DECLOSTATIN e broad-spectrum therapy that prevents monilial growth.

tiveness: Because its antibacterial component is DECLOMYCIN ethylchlortetracycline, DECLOSTATIN should be equally or more tive therapeutically than other tetracyclines in infections caused by cycline-sensitive organisms. The antifungal component, Nystatin, ects against superinfection by antibiotic-resistant fungal overgrowth ticularly monilia) in the intestinal tract.

raindication: History of hypersensitivity to demethylchlortetracy or nystatin.

ning: In renal impairment, usual doses may lead to excessive accumon and liver toxicity. Under such conditions, lower than usual doses ndicated, and, if therapy is prolonged, serum level determinations be advisable. A photodynamic reaction to natural or artificial sunhas been observed. Small amounts of drug and short exposure may uce an exaggerated sunburn reaction which may range from ery- a to severe skin manifestations. In a smaller proportion, photogic reactions have been reported. Patients should avoid direct sure to sunlight and discontinue drug at the first evidence of skin mfort. Necessary subsequent courses of treatment with tetracys should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

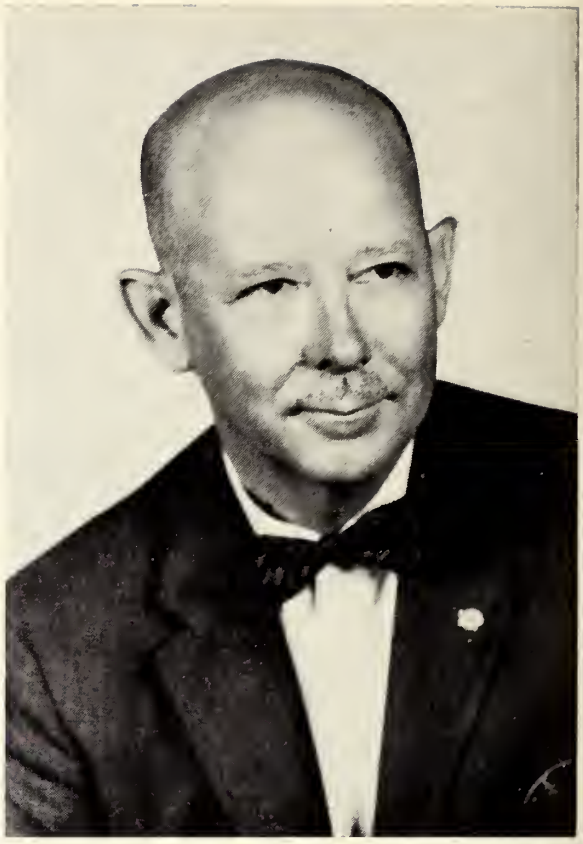
Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

President's Page



C. Kermit Pitt

In this my final Journal message as President of the Medical Association State of Alabama I again extend my deep appreciation for the honor of being allowed to serve during the last year. Also I wish to offer thanks to each member, committeeman and officer of the Association, as well as to the most capable and loyal mmebers of the central office staff. I am indebted to many groups, lay and professional, before whom I have appeared and who have without exception extended to me utmost courtesy and consideration.

Although our goals for the year were too high for complete accomplishment we all must feel some pride for the success we have enjoyed, more details of which will appear in my annual message to the Association in Mobile.

Assuring you of my continued interest in organized medicine and my willingness to serve wherever I may, I urge each of you to maintain your own involvement to the end that the health of our people may continue ever improved.

Again, thanks.

C. Kermit Pitt, M. D.

Do You Remember Chlorophyll?

Whatever became of chlorophyll? wonders The Wall Street Journal, which then proceeds to review the death throes of a fad that skyrocketed to fantastic success only 20 years ago.

Once upon a time The New Republic magazine called the rage for chlorophyll "a nationwide hysteria," and Life called those days "the era of good smelling." Manufacturers put measures of the green stuff into everything, and columnist Earl Wilson once suggested combining it with aspirin "for a stinking headache."

But the public became bored with the idea and today, says Wall Street's daily bible, one is hard put to find it in anything. It is still in one breath-sweetener, in one toothpaste, in an ointment for wounds, and in a dog food "to check body odors of dogs," but even there it has lost its sales appeal.

The Woman's Auxiliary

President, Mrs. Ben H. Johnson, Jr.
President-Elect, Mrs. Howard C. Johnson
Northeast District Vice President, Mrs. James D. Holliman, Jr.
Northwest District Vice President, Mrs. Gene Qualls
Southeast District Vice President, Mrs. George Andrews
Southwest District Vice President, Mrs. Andrew D. Henderson
WAMASA Editor, Mrs. William L. Smith

AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the Medical Association of the State of Alabama. I will support its activities, protect its reputation and ever sustain its high ideals."

The BIG NEWS at this time is the invitation to attend a luncheon meeting in Opelika to discuss the organization of an Auxiliary in Lee County. With 26 doctors in the Lee County Medical Society this will be a large Auxiliary and indeed we welcome the doctors' wives as Auxiliary members. We also congratulate Montgomery and Autauga counties for their merger into the Montgomery-Autauga Auxiliary. This is a large, fine group, and their accomplishments are many.

A visit to Calhoun County was a delight. A coffee was held to which had been invited all the wives of doctors in the surrounding counties. The girls were enthusiastic with plans for POISON PREVENTION Week, they have worked up a great project.

Jackson County has an active Auxiliary which emphasizes Health Careers. The members sponsor a large Health Careers Club in the High School and carried many high schoolers to Montgomery to the recent Health Careers Convention in Montgomery. The president, Mrs. Edward L. Trammell, has been an inspiration to me this year, and her courage sustained me in my recent dark days. Also, this is the only county in Alabama that is one hundred per cent AMPAC, husbands and wives. For a relatively small group, they do a BIG job.

This is almost the end of the row, and my last President's Page in the Journal. It has been very gratifying to have doctors and their wives tell me they have enjoyed reading my offerings, this makes it worth the considerable effort I have put forth on this important assignment. I have enjoyed the privilege of attending the meetings of the Board of Trustees, certainly I have a



Mrs. Ben H. Johnson

better understanding of the complexity of the Medical Association, our role in politics, and working with their committee on the Convention has been terrific. Together we have planned the best Convention ever, we know you will like it.

The honor and the responsibility of serving as President of the Auxiliary has meant so much to me, I have been busy, the rewards have been many. It has been just great visiting the County Auxiliaries, sharing their problems, and listening with amazement, sometimes, to the magnitude of their projects. Our membership has reached an

all time record, there are many new doctors in the state and their wives are taking an active role in the communities as Auxiliary members. This is really what being a doctor's wife is all about, how we relate to the community in which we live and in which our husbands work. We are lucky people.

Thank you, members of the Medical Association for the many courtesies shown me during this wonderful year. It has been my pleasure to meet you and work with you, and your wives are wonderful, friends that I shall not forget. May God be with you.



(Mrs. Ben H. Johnson, Jr.)
President, WAMASA

Cold Aggravates Angina Pectoris

Exposure to cold aggravates angina pectoris by increasing the resistance to blood flow through the small peripheral vessels, according to a National Heart Institute study presented at sessions of the American Heart Association Meeting in Bal Harbour, Florida.

The increased peripheral resistance raises the blood pressure against which the already oxygen-hungry heart muscle must work to supply the same volume of blood. This may bring on or else aggravate chest pains resulting from exertion or other factors in patients with chronic coronary insufficiency.

The study was reported by Drs. Morris Stampfer, Stephen Epstein, George Beiser, Robert Goldstein and Eugene Braunwald of the Heart Institute's Cardiology Branch.

This study included 6 coronary patients with angina and 5 subjects without any coronary symptoms. All 11 were studied both at rest and during mild exercise in both a warm (76°F) and a moderately cold (59°F) environment.

Both patients and controls showed significant increases in total peripheral resistance and in arterial pressure at rest and during exercise in the colder environment. Although heart output and heart rate were not changed as a result of the cooler temperature alone, 3 of the coronary patients who felt no pain while exercising in the warm environment incurred angina with the same level of exercise in the cold.

The worsening of angina with cold exposure is all too familiar to thousands of coronary patients for whom physical exercise is always limited, at some level, by the clenching chest pain of an insufficient blood supply to the heart muscle. Heavy outdoor work in an icy wind would be an extreme example of this effect; but stepping into chilly bath water, or even contact with cold sheets, is sufficient to trigger or worsen the chest pain in many patients.

Modern cardiology texts have opined that it is a cold-induced increase in heart output that increases the work—and consequently the painful need for oxygen—of the heart muscle in these patients. However, the results from the NHI study suggest otherwise.

Since a cold environment causes an increase in the total peripheral vascular resistance, but not in the cardiac output of the subjects, the authors feel that it is probably the increased resistance to flow peripherally and the consequent increase in blood pressure induced by cold which heightens the myocardial oxygen demand. If the coronary blood supply is insufficient, this factor might well precipitate or intensify any attack of chest pain.

—OSMA Journal



Remember how great milk of magnesia tasted?

Almost as good as castor oil.
But now you can spare the taste buds and spoil the patient with a modern Dulcolax tablet or suppository.

And Dulcolax works so predictably that the time of bowel movement can often be predicted. Tablets taken at night usually produce a bowel movement the following morning. Suppositories generally work in 15 minutes to an hour.

For preoperative preparation, a combination of tablets at night and a suppository the next morning usually cleans the bowel thoroughly.

Dulcolax suppositories may be particularly helpful when straining should be avoided, as in postoperative care. Keep in mind, however, that the drug is contraindicated in the acute surgical abdomen.

Dulcolax®...it's predictable
bisacodyl

cense from Boehringer Ingelheim G.m.b.H
Geigy Pharmaceuticals, Division of Geigy Chemical Corporation, Ardsley, New York 10502 DU-7015

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly reli by holding a hot roasted onion to the ea

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

IN ASTHMA
IN EMPHYSEMA



optional therapy

THE mudranes®

All Mudranes are bronchodilator-mucolytic in action, and are indicated for symptomatic relief of bronchial asthma, emphysema, bronchiectasis and chronic bronchitis. **MUDRANE tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **Iodide side-effects:** May cause nausea. Very long use may cause goiter. Discontinue if symptoms of iodism develop. **Iodide contraindications:** Tuberculosis; pregnancy (to protect the fetus against possible depression of thyroid activity). **MUDRANE-2 tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline. **Iodide side-effects and contraindications are listed above. MUDRANE GG tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **MUDRANE GG-2 tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions:** Those for aminophylline. **MUDRANE GG Elixir.** Each teaspoonful (5 cc) contains 26 mg. glyceryl guaiacolate; 20 mg. theophylline; 5.4 mg. phenobarbital (Warning: may be habit-forming); 4 mg. ephedrine HCl. **Dosage:** Children, 1 cc for each 10 lbs. of body weight; one teaspoonful (5 cc) for a 50 lb. child. Dose may be repeated 3 or 4 times a day. Adult, one tablespoonful, 4 times daily. All doses should be followed with ½ to full glass of water. **Precautions:** See those listed above for Mudrane GG tablets.

MUDRANE—original formula
First choice

MUDRANE-2
When ephedrine is too exciting or is contraindicated

MUDRANE GG
During pregnancy or when K.I. is contraindicated or not tolerated

MUDRANE GG-2
A counterpart for Mudrane-2

MUDRANE GG ELIXIR
For pediatric use or where liquids are preferred

Clinical specimens available to physicians.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals



CAUTION:

OVEREATING MAY BE HAZARDOUS TO YOUR HEALTH.

According to the Framingham Heart Study, the obese face:

86% greater risk of angina pectoris,
82% greater risk of diabetes,
71% greater risk of coronary heart disease.*

Obesity may also aggravate osteoarthritis, flat feet, intertriginous dermatitis, varicose veins, and ventral or diaphragmatic hernias.[1-3]

ou are considering weight reduction, consider

Preludin®
phenmetrazine hydrochloride
Endurets®
prolonged-action tablets

Often effective

Controlled studies in a general patient population have shown that when Preludin is used with diet, the rate of weight loss exceeds that obtained by placebo and diet.

Long acting

Slow, even release of the active principle usually suppresses appetite continuously for about 12 hours.

Once-a-day dosage

One Endurets tablet after breakfast. It helps reduce weight and costs, conveniently.

For contraindications, warning, precautions, and adverse reactions, please see the full prescribing information.
It is summarized on this page.

Where there's no will there's a therapeutic way.

*Among persons 20% or more overweight as compared with median weight for persons of like height and sex.

1. Kannel, W.B., *et al.*: *Circulation* 35:734, 1967.
2. Thomas, H.E., Jr., *et al.*: *Med. Times* 95:1099, 1967.
3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

Preludin®
phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by mid-morning.

Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.
Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000.
(B)R3-46-560-B

For complete details, please see full prescribing information.

Under license from
Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

PR-7169



Massachusetts Doctors Attack Secret-Inquest Decision

The closing of inquests to the public and the news media in Massachusetts has drawn an editorial challenge from *Massachusetts Physician,* the official organ of that State's Medical Association. "The implications of this decision should be weighed entirely apart from the immediate case which prompted the ruling," the editorial insists.

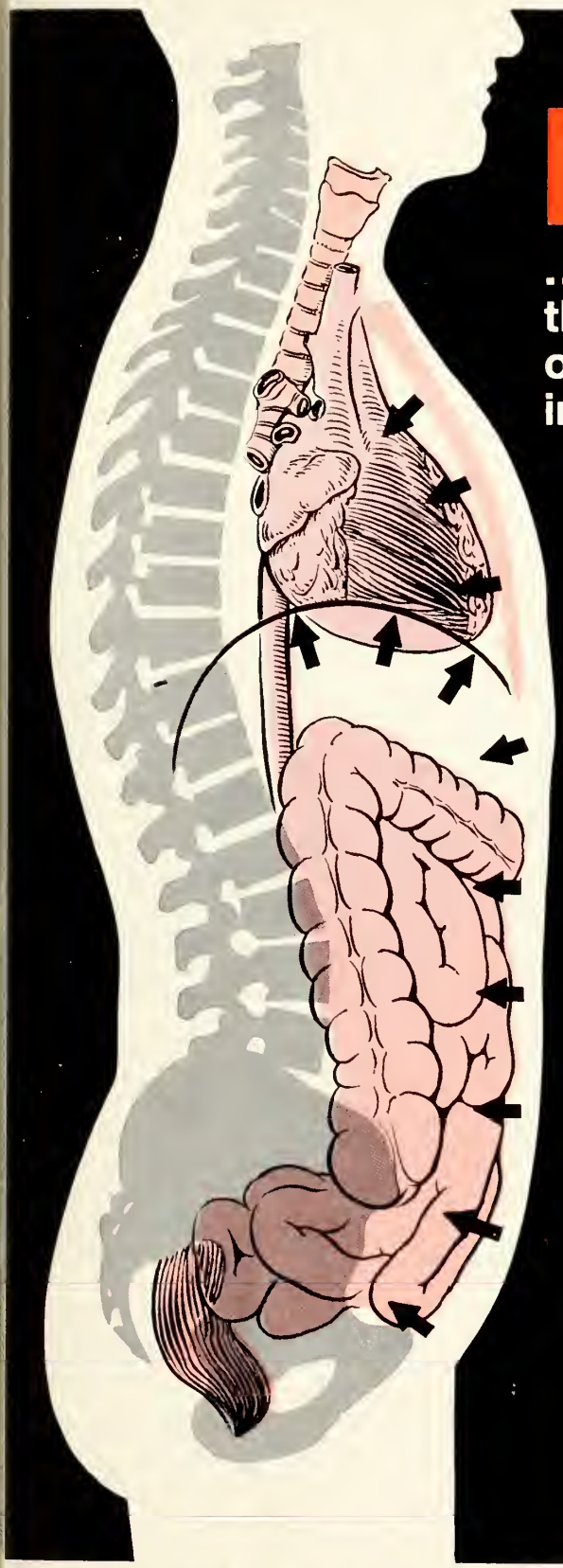
Probably the most important witness at any inquest is the physician. Much of his testimony is factual. Only his conclusions are apt to be opinion. And it is unfortunate, thinks the editorial, that physicians are generally unwilling to admit that "I don't know the cause of death." The MD does not necessarily determine the *legal* cause of death. "If a death is determined to be due to trauma resulting from a fall, the physician certifying the death (whether a legally constituted medical examiner or a private physician) cannot know whether the subject fell as a result of: a push (murder), a voluntary jump (suicide), a pure accident, or syncope secondary to another disease."

The editorial observes that death conferences have become common practice in many hospitals; that deaths occurring in a given period of time are reviewed in a meeting open to the entire medical staff; and that one of the results is that the listing of the cause of death is likely to be much more accurate. The fact that his fellow MDs will review the case makes the physician more aware of the need to substantiate the diagnosis with adequate medical evidence. "Therefore, it seems rather strange," continues the article, "that in the very situations in which cause of death is questioned by the law, the testimony of the medical examiner or other physicians involved will no longer be available for the peer review we consider so necessary to hospital practice."

Pointing out that "we are physicians, not lawyers," and that investigations have historically been held openly both in this country and England, where much of our legal procedure originated, and that the possibility of murder must always be considered, the editorial concludes with an open challenge to the decision of the Supreme Judicial Court of Massachusetts:

"This is a public, not a private matter; no one is entitled to secrecy. We believe that open hearings are much more likely to determine the true cause of death. We hope our legal colleagues will consider the wisdom of this court decision and determine whether a higher court should not be asked to review it."

(Continued on Page 900)



DOXIDAN®

...to reduce the hemodynamic "bind" of constipation in congestive heart failure

Constipation in the chronic heart failure patient carries with it the ever-present threat of acute cardiac decompensation while straining at stool. In the already weakened, distended heart, a sudden influx of blood on termination of the Valsalva maneuver is considered to be the mechanism of some of the deaths occurring in these cardiac patients during straining efforts.*



Doxidan is a gentle laxative designed to free your patient from the hemodynamic consequences of straining at stool. With a fecal softening agent to keep the stool soft and easy to evacuate, and with just enough peristaltic stimulation to urge the sluggish bowel, Doxidan reduces the hemodynamic "bind" of constipation.

Composition: Each capsule contains 50 mg. danthron N.F. and 60 mg. dioctyl calcium sulfosuccinate.

Dosage: Adults and children over 12—one or two capsules daily. Children 6 to 12—one capsule daily. Give at bedtime for two or three days or until bowel movements are normal.

Supplied: Bottles of 30, 100 (FSN 6505-074-3169) and 1000 (FSN 6505-890-1247).

*Best, C. H. and Taylor, N. B.: *The Physiological Basis of Medical Practice*, 7th edition, Williams and Wilkins, Baltimore, 1961, p. 480.

DOXIDAN®

HOECHST
PHARMACEUTICAL CO.
Div. American Hoechst Corp.
Cincinnati, Ohio 45229 U.S.A.

C-124

(Continued from Page 898)

Question of Morality Raised in Organ Donation

Neil Armstrong found it only a short step from his landing vehicle to the surface of the moon, but a great leap forward for mankind.

So the life span of two centennarians placed end-to-end may seem a brief segment of history, but we have come a long way from the 18th century practice of grave-robbing to provide research material for medicine, to today's practice of organ donation for transplant purposes.

The donation of the dead to benefit the living is not without precedent. Old Gaius Petronius, the Roman satirist and "judge of elegance," tells the story of the lovely widow mourning in the tomb beside the body of her late husband.

Nearby was a soldier, stationed by the gibbet to guard the body of a hanged criminal. Shivering, he sought the protection of the tomb from the bone-chilling cold, surprising the widow at her mourning. After their initial and startled confrontation, they became well acquainted indeed.

An hour or so later, the soldier returned to his post, only to find to his horror that the family of the executed criminal had stolen his body away. He faced court martial and the penalty was death. The widow solved his problem for him by substituting the cadaver of her late husband for the missing criminal.

An article in the Hawaii Medical Journal recalled the recent visit to our 50th State by Dr. David Daube, Regius Professor of Civil Law at Oxford University. Dr. Daube, member of an ad hoc commission appointed by the British Ministry of Health to consider legislation on the subject of organ transplantation, freely expressed his opinion on the subject.

Cadavers, he felt, should be generally available for transplant purposes, with three exceptions: 1) where it is known or may be presumed that it would be against the wishes of the deceased person; 2) where it is objected to by the mate or parents; and 3) where foul play is suspected or known to have occurred.

Dr. Daube listed three sources of organ transplants as taboo for moral reasons and that should be outlawed: children under 18, prisoners, and inmates of mental hospitals. He felt that these were unable, because of either immaturity, circumstances, or inherent mental defect, from exercising mature, informed consent to the procedure. He dropped the age of consent because he thought 21 an unnecessarily advanced age limit.

Doctors are not the only ones involved in the broad problem of medical experimentation, Dr. Daube felt. "Educators, psychologists, and others are quite as much involved, and they run as much risk of doing harm. Psychological experiments . . . and educational experiments . . . need to be studied with as much care as in medical experiments." He pointed out that the risk of harm to the subjects or participants in psychological experiments or educational experiments is just as great as in medical experiments.

Which, for Alabama and the Deep South in particular, the nation in general, is a thought-provoker of profound importance.

(Continued on Page 902)

The AMBAR SCRAPBOOK of Obesity Oddities
FACT & LEGEND

IF THEY FIT.. THEY'RE FREE!

LEVI STRAUSS & CO. WILL GIVE A FREE PAIR OF LEVI'S TO ANYONE WHO MEASURES OUT TO A **76** INCH WAIST!



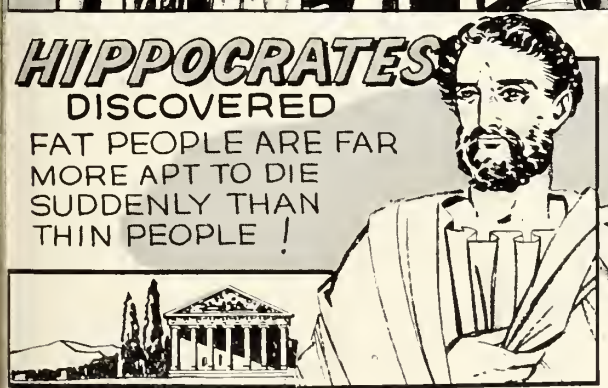
ROMANS

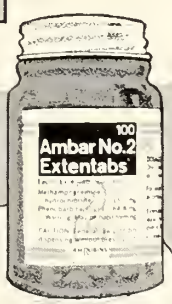
DRINKING TO A LADY'S HEALTH, QUAFFED ONE CUP OF WINE FOR EVERY LETTER OF HER NAME!



HIPPOCRATES

DISCOVERED FAT PEOPLE ARE FAR MORE APT TO DIE SUDDENLY THAN THIN PEOPLE !







THE COST OF **AMBAR EXTENTABS**

IS APPROXIMATELY 10% TO 40% LESS THAN THAT OF OTHER LEADING APPETITE SUPPRESSANTS

AN IMPORTANT FACTOR IN LONG TERM THERAPY

Control food and mood all day long with a single morning dose

AMBAR #2

EXTENTABS® methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

A. H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS

One Ambar Extentab before breakfast can help control most patients' appetites for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety . . . helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the will power during periods of dieting.

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

Also available: Ambar #1 Extentabs® — methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

(Continued from Page 900)

Old Venereal Disease Fire Horse Hears The Bell Clang Again

Out at the Induction Center at Gunter Air Base, in cooperation with Dr. Smigiel, Captain U. S. Army, and Dr. Fieselman, Captain U. S. Air Force, the future men of the Armed Forces are examined. The men, in groups of 30 or less, are screened, after the necessary laboratory tests, and then they are profiled for induction or not.

The defects encountered are numerous. Probably most physicians would think that "flat feet" would be the commonest defect, but by the "Smith's test" many of the so-called flat feet have very good arches when they stand on their tiptoes, and have no pain in their feet. But the really flat footed man has, on standing tiptoed, feet as flat as a board or pancake.

Probably the commonest defect is left varicocoele, and very occasionally, right varicocoele. These "bag of worms" vary from small bags to those that can be seen half way across a room. Hernias are frequent, but not nearly as common at the inspection since many have been operated on previous to the examination.

Injuries in joints, knees, ankles, elbows and shoulders are quite common and occur usually in the football or basketball player.

Hypospadias is not too uncommon, but epispadias have been seen in only one person of the recent several thousand examined. While looking for penile defects recently, up popped a primary syphilis lesion, the Chancre. It was fairly firm, but not hard like the "Hunterian Chancre" and extended from the underside of the meatus through the torn frenum, which he claimed had been torn four nights previously. He had a right-sided, very hard inguinal bubo and his R. P. R. card test was strongly positive. Since the station takes inductees from North Florida and all of Alabama, it was interesting to know the man, colored, 19, was from Pensacola, Florida. And the old venereal disease fire horse sprung into action. Mr. John J. Hill, Field Force Director, was called at once and given the details. He, in turn, called the director in Florida and by the time the bus arrived in Pensacola a man was waiting, but the patient eluded him. By going to the home of the man, he was given the name of the patient's girl friend and he was found in bed with her. She was found to have secondary syphilis and the chase began in earnest and the "Blitz" was on. She was an unnamed syphilis contact from an active case in Florida and was a missed contact of another infected male several weeks before. This proves one thing, the activity of the "Blitz" with its speed will eventually control syphilis.

W. H. Y. Smith, M.D.

The Doctor's Changing Image

One reason for the high rise in malpractice suits and awards, says a recent article in *Group Practice*, journal of the American Association of Medical Clinics, is the change in the doctor's image. According to one witness who has specialized in defending doctors against malpractice suits, "The doctor's image is sadly tarnished. Once thought of as 'the old country doctor driving through the rain all night to sit beside a sick patient' they are now thought of as 'supersuccessful business men.' " This image, the witness suggested, which an AMA statement supported, "makes patients more willing to sue their doctors and makes juries more willing to return a verdict."

Group Practice is quoting from the report of Senator Abraham Ribicoff (D-Conn.) for his Senate Subcommittee on Executive Reorganization. His 1,047-page report, "Medical Malpractice: the Patient vs. the Physician," stems from an intensive nine-month probe of statements by insurance firms, the AMA, the American Hospital Association, and lawyers on both sides of malpractice suits.

A Month For Monuments For Medicine

April is good medicine, and the fact is well illustrated by a quick rundown of significant dates in this fourth month of the year—which, before Julius Caesar, was the second month of the year:

1st: Birthday of William Harvey, English physician, discoverer of the circulation of the blood (1578).

4th: After five years of research, Prof. C. G. King of the University of Pittsburgh, isolates Vitamin C (1932).

5th: Birthday of Sir Joseph Lister, English surgeon, founder of modern antiseptic surgery (1827).

12th: News flash from Ann Arbor, Mich. (1955): Salk vaccine works! Safe, effective, potent.

15th: Insulin, discovered by Dr. Frederick Banting of Toronto the year before, becomes available for general use on this date (1923).

20th: Marie and Pierre Curie (1902) isolate one gram of radium salts from about eight tons of pitchblende and determine the atomic weights and properties of radium and polonium.

It was in April that Donald Culross Peattie, the poet-philosopher, looked out over his world and wrote:

"Man has the world in the hollow of his hand. He is a standing refutation of an old superstition like predestination—or a new one like determinism. His chances seem all but boundless, and boundless might be his optimism if he had not already thrown away so many of his opportunities . . .

"That very marsh was the home of waterfowl as valuable as they were beautiful. Now they must die, because in this world all breeding grounds are already crammed full. When he slays the birds, he lets loose their prey—and his worst enemy—the insects. He wastes his forests faster than he replaces them, and slaughters the mink and the beaver and the seal. He devours his limited coal supply ever faster; he fouls the rivers, invents poison gases and turns his destruction even on his own kind.

"And in the end he may present the spectacle of some Brobdingnagian spoiled baby, gulping down his cake and howling for it too."

Noise As A Menace To Health

Medical Authorities are probing the theory that loud noises can harm the human body in other ways than causing hearing loss.

Preliminary studies indicate that weeks of exposure to high noise levels, such as found in factories, can elevate cholesterol levels and increase buildup of fatty substances in the blood.

Investigators have found that prolonged exposure to noise or sudden sharp noise produces involuntary responses by vascular, digestive, and nervous systems.

The short-term physiologic effects of noise, according to Dr. Samuel Rosen of New York, are: "Epinephrine is shot into the blood, as during stress and anxiety. The heart beats rapidly, blood vessels constrict, pupils dilate, the head turns, the skin pales, and the stomach, esophagus, and intestines are seized by spasms. When the noise is prolonged, there are heart flutters that eventually subside when the noise diminishes."

The fact that noise can cause vascular constriction is particularly dangerous in individuals whose arteries already are narrowed by atherosclerosis.

—Today's Health.

Program

of the

109th ANNUAL SESSION

of the

MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

MOBILE MUNICIPAL AUDITORIUM

MOBILE

APRIL 30, MAY 1, 2, 1970

The 109th Annual Session of the Medical Association of the State of Alabama will convene at 9 A. M., on Thursday, April 30, 1970, in Room 3, Mobile Municipal Auditorium, Mobile, Alabama.

The opening session will be called to order by C. Kermit Pitt, M. D., President of the Association. It will be followed immediately by the Orientation Program for new members with S. Buford Word, M. D., President-Elect, presiding.

Three scientific sessions will be held, also in the Mobile Municipal Auditorium featuring outstanding speakers.

Registration

The registration desk for Counsellors, Delegates, members of the Association, guests and exhibitors will be opened at 8. A. M. to 5 P. M., on Wednesday, April 29, in the lobby of the Admiral Semmes Hotel.

On Thursday and Friday, April 30 and May 1, the registration desk will be open from 8 A. M. to 5 P. M. in the lobby at the main entrance to the Municipal Auditorium. On Saturday, May 2, the registration desk will be open from 7:30 A. M. until 10 A. M.

Counsellors and Delegates will be registered in advance and may claim their badges, the offiical program, President's Message and other material upon signing the official registration card.

Members and guests will be registered at the same places upon signing registration cards.

Exhibitors Registration

Exhibitors are requested to register on Wednesday, April 29, between the hours of 8 A. M. to 5 P. M., at the registration desk in the Admiral Semmes Hotel lobby. Thereafter exhibitors may register at the Municipal Auditorium.

Badges

No person will be admitted to any scientific, business, or social session of the Association, or to the exhibit area, unless he or she wears an official badge.

Speakers

Speakers will be called in the order in which they appear on the program. Should a speaker be absent when called, his paper will be passed and called again upon conclusion of the program.

Hotel Reservations

The Central Office of the Medical Association of the State of Alabama has established a Housing Bureau for the convenience of Counsellors, Delegates and members.

Advance registration requests were distributed in the March issue of the Journal of the Medical Association of the State of Alabama.

The headquarters hotel will be the Admiral Semmes Hotel. No rooms are available at the Admiral Semmes Motel; Downtown Holiday Inn of Mobile or Malaga Inn.

Deadline for advance registration is April 1, 1970. After that date, reservations must be made directly with the hotel or motel.

Social Events

A full listing of social events of the 109th Annual Session will be published in the official program, available at the time of registration. Meetings of medical specialty groups will be scheduled either before or after the Annual Session inasmuch as the Constitution and Ordinances forbids this type of meeting during the three days allotted to the Annual Session. Social events for specialty groups and alumni organizations will be held on Thursday, April 30, 1970, at the places and times to be announced.

Tickets for social events should be purchased in advance if possible. Otherwise, a limited number will be available at the registration desk.

Awards Dinner

The Awards Dinner will be held in the Admiral Semmes Hotel Ballroom at 7 P. M., on Friday, May 1, 1970. The dinner will be sponsored by the Committee on Public Relations in honor of the winners of the 1970 awards, past presidents, and members of the Fifty Year Club. The following new members will be inducted into the Fifty Year Club:

James G. Daves, M. D., Cullman

Herbert B. Dowling, Jr., M. D., Mobile

William E. McGrath, M. D., Sheffield

James L. Taylor, M. D., Mobile

William G. Thuss, M. D., Birmingham

Henry O. Walker, M. D., Huntsville

Maurice S. Whiteside, M. D., Cullman

Frank C. Wilson, M. D., Birmingham

Gerald G. Woodruff, Sr., M. D., Anniston

Lewis G. Woodson, Jr., M. D., Birmingham

Awards will be presented by Ira B. Patton, M. D., Chairman of the Committee on Public Relations, to the following:

William Crawford Gorgas Award to the citizen of Alabama who is not actively engaged full time in the field of health and who has rendered outstanding service: Mr. Fred W. Abt, Cullman.

William H. Sanders Award to the person, lay or professional, engaged full time in public health work for services above and beyond the call of duty: Harold Klingler, M. D., Montgomery.

Douglas L. Cannon Medical Reporter Awards to the reporters, editors or publishers, of an Alabama newspaper, or to radio television personalities who have shown excellence in factual reporting of medical news and for outstanding efforts in elevating medical news coverage: Miss Anita Smith, Birmingham News, Birmingham; Mr. Dave Williams, WFPA Radio, Fort Payne, and Mr. Don Chapin, Huntsville Times, Huntsville.

The A. H. Robins Community Service Award for the physician who has rendered outstanding service to his community above and beyond his professional call of duty: C. L. Salter, M. D., Talladega.

Board of Trustees

The Board of Trustees will meet at 10 A. M., on Wednesday, April 29, 1970, in Room 205, Mezzanine Floor, at the Admiral Semmes Hotel, to sit as a reference committee in consideration of any and all matters of business to be presented at the 109th Annual Session. All Counsellors, Delegates and members of the Association are cordially invited to sit with the Board of Trustees and to present their views on matters under consideration.

Board of Censors

The Board of Censors will meet at 9 A. M., on Wednesday, April 29, 1970, in Room 1223, Wallace Pitts Suite, of the Admiral Semmes Hotel, to transact official business concerning the State Board of Medical Examiners

and the State Committee on Public Health. Upon completion of discussions relating to the Board of Medical Examiners and the Committee on Public Health, the Board of Censors will convene to officially consider Assocoation affairs, including matters referred by the Board of Trustees.

Other Events

Wednesday, April 29, 1970

Alabama Chapter, American Academy of Pediatrics

The Alabama Chapter, American Academy of Pediatrics will hold an all-day scientific and business meeting beginning at 9 A. M., at the Malaga Inn, Mobile. Reception and Dinner, 6:30 p. m., International Trade Club.

Alabama Orthopaedic Society

The Alabama Orthopaedic Society will hold a scientific and business session beginning at 10 A. M., at the Mobile Infirmary Auditorium, Mobile, followed by lunch. Cocktails and dinner will begin at 6:30 P. M. at the International Trade Club.

Exhibitors Reception

The annual reception for representatives of exhibitors at the 109th Annual Session will be held from 5:30 P. M. to 6:30 P. M., Mezzanine Floor of the Admiral Semmes Hotel. Officers and members of the Board of Censors and Board of Trustees will be hosts at this reception.

Alabama Academy of Neurology and Psychiatry

The Alabama Academy of Neurology and Psychiatry will have a dinner meeting at 7:30 P. M., in Rooms 205 and 206, Mezzanine Floor of the Admiral Semmes Hotel.

Alabama Industrial Medical Association

The Alabama Industrial Medical Association will hold a social hour at 6:30 P. M. and dinner at 7:30 P .M. in the Alabama Room of the Admiral Semmes Hotel.

Alabama Thoracic Society

The Alabama Thoracic Society will hold a dinner meeting at 6:30 P. M. in the Ballroom B, Mezzanine Floor of the Admiral Semmes Hotel.

Alabama Society of Anesthesiologists

The Alabama Society of Anesthesiologists will hold a dinner at 7:30 P. M. at the International Trade Club, Mobile.

Thursday, April 30, 1970

Woman's Auxiliary to the Medical Association of the State of Alabama

The Woman's Auxiliary to the Medical Association of the State of Alabama will hold a luncheon at 12:30 P. M. in Ballrooms A and B of the Admiral Semmes Hotel.

Alumni Meetings

Vanderbilt Alumni Reception, 6 P. M. to 7:30 P. M., Room 206 at the Admiral Semmes Hotel.

Tulane Alumni Reception, 5:30 P. M. to 7:30 P. M., Room 205 at the Admiral Semmes Hotel.

University of Alabama Alumni Reception and Dinner, 6:00 P. M., Ballroom, Admiral Semmes Hotel.

Gas Light Party

The Gas Light Party will begin at 7:30 P. M., in the Main Arena of the Mobile Municipal Auditorium. The party will be sponsored by the Woman's Auxiliary to the Medical Association of the State of Alabama and the Medical Society of Mobile County.

Friday, May 1, 1970

International College of Surgeons

The International College of Surgeons will hold a breakfast meeting at 7:30 A. M., Malaga Inn, Mobile.

Medical Class of 1910 Reunion

The Medical Class of 1910, School of Medicine of the University of Alabama, will hold a luncheon at 12:30 P. M., Room 205, Admiral Semmes Hotel.

ALAPAC Luncheon

The Fifth Annual ALAPAC Luncheon will be held at 12:30 P. M. in Ballrooms A and B, Admiral Semmes Hotel.

Awards Dinner

The Awards Dinner will be held in Ballrooms A and B, at 7:30 P. M., Admiral Semmes Hotel, with Governor Albert P. Brewer as guest speaker. To be honored at the Awards Dinner are Past Presidents of the Association; members of the Fifty Year Club; and winners of the William Crawford Gorgas Award, Douglas L. Cannon Medical Reporter Awards, William Henry Sanders Award, and the A. H. Robins Community Service Award.

Saturday, May 2, 1970

Alabama Chapter, American College of Radiology

The Alabama Chapter, American College of Radiology will hold a luncheon meeting at 1:30 P. M. in the Alabama Room of the Admiral Semmes Hotel.

Alabama Academy of Opthalmology and Otolaryngology

The Alabama Academy of Opthalmology and Otolaryngology will hold a business meeting beginning at 1:30 P. M. in Room 205 of the Admiral Semmes Hotel.

Hosts of the Association

Official hosts of the Association will be the Medical Society of Mobile County, William T. Wright, M. D., President. A Host Committee will be assigned to provide transportation and escort for visiting dignitaries.

PROGRAM

Opening Session

Thursday, April 30, 1970

Mobile Municipal Auditorium



C. Kermit Pitt, M. D., Decatur, President, Presiding

9:00 A. M.

Call to Order



Invocation

Dr. Joel D. McDavid, Minister, Dauphin Way United Methodist Church, Mobile

9:05 A. M.



Welcome Address

Honorable Joseph A. Bailey, Mayor, Mobile

9:10 A. M.



Welcome Address

William T. Wright, M. D., President, Medical Society of Mobile County

Orientation

Mobile Municipal Auditorium



S. Buford Word, M. D., Birmingham, President-Elect, Presiding

9 15-9:35 A. M.

The Now Medical Generation Gop



Joseph H. Sugg, M. D., Resident in Surgery, Department of Surgery, University of Alabama School of Medicine, Birmingham

9:35-9:55 A. M.



What's In It For Her?

Mrs. John M. Chenault, President, Woman's Auxiliary to The American Medical Association, Decatur

9:55-10:15 A. M.

Errors In Prescribing Narcotics



Ira L. Myers, M. D., State Health Officer, Montgomery

10:15-10:30 A. M.

Coffee Break—View Exhibits

10:30-11:00 A. M.

Doctor—Take The Time, Make The Effort



Honorable Otis R. Bowen, M. D., Speaker, House of Representatives, State of Indiana, Bremen, Indiana

11:00-11:30 A. M.

Changing Trends In Malpractice Litigation



Honorable Walter P. Gewin, Judge, U. S. Court of Appeals, Fifth Judicial District, Tuscaloosa

11:30-12:00 Noon

President's Message

C. Kermit Pitt, M. D., Decatur

WOMAN'S AUXILIARY LUNCHEON

Thursday, April 30, 1970

Ballroom A and B

Admiral Semmes Hotel

12:30 P. M.



Mrs. Ben H. Johnson, Jr., President, Woman's Auxiliary to the Medical Association of the State of Alabama, Bessemer, Presiding

Invocation

Introduction of Distinguished Guests

Presentation of AMA-ERF Contribution

To Clifton K. Meador, M. D., Dean, University of Alabama School of Medicine by Mrs. Richard A. Dillard, State AMA-ERF Chairman







Principal Speaker

Father Daniel Egan, New York, New York

First Scientific Session

Thursday, April 30, 1970

Mobile Municipal Auditorium

C. Kermit Pitt, M. D., Decatur, President, Presiding

2:00-2:40 P. M.

Achieving Health Goals: A Team Approach



Gerald D. Dorman, M. D., President, American Medical Association, New York, New York

2:40-3:20 P. M.

Planning New Programs For Better Health Care



S. Richardson Hill, Jr., M. D., Vice President for Health Affairs, University of Alabama School of Medicine, Birmingham

3:20-4:00 P. M.

Obstetrics and Gynecology in The 20th Century



Charles E. Flowers, Jr., M. D., Professor and Chairman, Department of Obstetrics and Gynecology, University of Alabama School of Medicine, Birmingham

Coffee Break—View Exhibits

4:15-4:55 P. M.



Allergy In Children

Claude Frazier, M. D., Chief of Allergy, Memorial Mission Hospital, Asheville, N. C.

4:55-5:35 P. M.

Speed Freaks And Pot Heads



W. A. Daniel, Jr., M. D., Professor, Department of Pediatrics; Director, Adolescent Division, Pediatrics, University of Alabama School of Medicine, Birmingham

Second Scientific Session

Friday, May 1, 1970

Mobile Municipal Auditorium

C. Kermit Pitt, M. D., Decatur
President, Presiding

9:00-9:45 A. M.

Medical Education And Practice



Eugene A. Stead, Jr., M. D., Professor of Medicine, Duke University, Durham, North Carolina

9:45-10:30 A. M.

Cancer Immunity



Richard T. Smith, M. D., Chairman, Department of Pathology, University of Florida Medical School, Gainesville, Florida

10:30-10:50 A. M.

Coffee Break—View Exhibits

10:50-11:40 A. M.

Jerome Cochran Lecture

Development of Arterial Grafts and Vascular Surgery in Alabama



W. Sterling Edwards III, M. D., Professor of Surgery, University of New Mexico Medical School, Albuquerque, New Mexico

11:45 A. M.

Caucus of Counsellors and Delegates

ALAPAC LUNCHEON

Friday, May 1, 1970

Ballrooms A and B

Admiral Semmes Hotel

12:30 P. M.



Grover C. Murchison, Jr., M. D., Montgomery, Chairman, ALAPAC, Presiding

Invocation

Dr. Massey M. Heltzel, Minister, Government Street Presbyterian Church, Mobile



Introduction of ALAPAC Board of Directors and Other Notables at Speakers Table

Introduction of Speakers

S. Buford Word, M. D., Birmingham, President-Elect

Remarks

Honorable Otis R. Bowen, M. D., Speaker, Indiana House of Representatives, Bremen, Indiana

Address



Honorable G. Robert Bartron, M. D., Member, South Dakota State Senate, Watertown, South Dakota

Adjourn

Third Scientific Session

Friday, May 1, 1970

Mobile Municipal Auditorium

William A. Walker, M. D., Decatur
President, Presiding

2:00-2:45 P. M.

Recent Advances in Surgical Treatment of Cardiac Disease



Denton A. Cooley, M. D., Surgeon-In-Chief, Texas Heart Institute, Houston, Texas

2:45-3:30 P. M.

Immunologic Deficiency Diseases



Max D. Cooper, M. D., Professor, Department of Pediatrics; Associate Professor, Department of Microbiology, University of Alabama School of Medicine, Birmingham

3:30-3:50 P. M.

Coffee Break—View Exhibits

3:50-4:35 P. M.

The Pulmonary Vasculature in the Diagnosis of Heart Disease



Richard G. Lester, M. D., Professor and Chairman, Department of Radiology, Duke University Medical Center, Durham, North Carolina

4:35-5:30 P. M.

Project Hope In Tunisia



Mr. Ronald C. Merrell, Medical Student, University of Alabama School of Medicine, Birmingham

Awards Dinner

Friday, May 1, 1970
7:00 P. M.
Admiral Semmes Hotel Ballroom



Presiding Ira B. Patton, M. D., Chairman, Committee on Public Relations, Oneonta



Invocation

The Most Rev. John L. May, Bishop of the Mobile Diocese Catholic Church, Mobile



Awards Presentations

E. W. Stevenson, M. D., Birmingham



William Crawford Gorgas Award

Mr. Fred W. Abt



William Henry Sanders Award

Harold Klingler, M. D.



Douglas L. Cannon Medical Reporter Award

Miss Anita Smith

The Birmingham News
Birmingham, Ala.

Mr. Dave Williams
WFPA Radio
Fort Payne, Ala.

Mr. Don Chapin

The Huntsville Times
Huntsville, Ala.

Presentation, A. H. Robins Community Service Award By

R. F. Bliss, M. D., President, Talladega County Medical Society, Talladega

Clarence L. Salter, M. D.

Introduction of Distinguished Guests and Fraternal Delegates

C. Kermit Pitt, M. D., President Medical Association of the State of Alabama

Presentation of Fifty Year Club Members


Dr. Daves

James G. Daves, M. D., Cullman

Herbert B. Dowling, Jr., M. D., Mobile


Dr. McGrath

William E. McGrath, M. D., Sheffield

James L. Taylor, M. D., Mobile

William G. Thuss, M. D., Birmingham


Dr. Taylor

Henry O. Walker, M. D., Huntsville

Maurice S. Whiteside, M. D., Cullman


Dr. Walker

Frank C. Wilson, M. D., Birmingham

Gerald G. Woodruff, Sr., M. D., Anniston


Dr. Woodruff

Lewis G. Woodson, Jr., M. D. Birmingham

Introduction of Past Presidents


Dr. Woodson

E. L. McCafferty, Jr., M. D.
E. Bryce Robinson, Jr., M. D.
J. O. Finney, M. D.
James G. Donald, M. D.
E. B. Glenn, M. D.
James G. Daves, M. D.
M. Vaun Adams, M. D.
John W. Simpson, M. D.
Hugh E. Gray, M. D.
William R. Carter, M. D.
Edgar G. Givhan, Jr., M. D.
John A. Martin, M. D.
Grady O. Segrest, M. D.
J. Orville Morgan, M. D.
B. W. McNease, M. D.
T. Brannon Hubbard, M. D.
Joseph M. Weldon, M. D.
Frank C. Wilson, M. D.
John Paul Jones, M. D.
Jesse P. Chapman, M. D.
James R. Garber, M. D.
J. D. Heacock, M. D.



Address

Honorable Albert P. Brewer,
Governor,
State of Alabama

Adjourn

Acknowledgements

(The Association gratefully acknowledges the financial contribution made by Blue Cross-Blue Shield of Alabama, Inc.; Geigy Pharmaceuticals; Bristol Laboratories and S. E. Massengill Company.)

Annual Business Session

Saturday, May 2, 1970

Mobile Municipal Auditorium

C. Kermit Pitt, M. D., Decatur,
President, Presiding

9:00 A. M.

Presentation by The Woman's Auxiliary to The Medical Association of the State of Alabama

Mrs. Ben H. Johnson, Jr.,

Bessemer, Immediate Past-President

(1) Report of The Board of Censors

(2) Revision of the Rolls
  (a) County Societies;
  (b) Counsellors;
  (c) Correspondents

(3) Election and Installation of Officers

(4) Presentation of Past President's Plaque

Adjournment


Each 5 cc. contain erythromycin estolate equivalent to 250 mg. erythromycin base.
When mixed as directed, each 5 cc. will contain erythromycin estolate equivalent to 125 mg. erythromycin base.
When mixed as directed, each cc. will contain erythromycin estolate equivalent to 100 mg. erythromycin base.
Each 5 cc. contain erythromycin estolate equivalent to 125 mg. erythromycin base.
Each tablet contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule® contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule contains erythromycin estolate equivalent to 250 mg. erythromycin base.
The many forms of Ilosone®
Erythromycin Estolate
Lilly
Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206
900761

THE JOURNAL
of
THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA
Published Under the Auspices of the Board of Censors

Volume 39 April, 1970 No. 10

Peripheral Vascular Injuries

Henry L. Laws, M. D.

Anniston, Alabama

Introduction

Traumatic deaths prior to hospital arrival occur from brain injury, mechanical dysfunction of ventilation, hemorrhage from a major vessel or solid organ, or a combination of these factors. Most individuals with penetrating wounds who die prior to hospital arrival, have a major vascular injury. Many individuals with such a wound, however, do survive long enough for institution of therapy. This report entails my personal experience with vascular wounds and a brief outline of the proper management of such injuries. Notations of cardiac and pulmonary wounds are excluded from this report. Likewise, a number of negative explorations which were done are excluded.

The first successful arterial repair is said to be that of Murphy[14] who used invagination of the proximal artery into the distal artery for reconstruction in 1897. Since the descriptions of Carrel and Guthrie[2] of suture techniques in 1906, only sporadic arterial repair was done until the time of World War II. In general, arterial injuries were treated by ligation.

DeBakey and Simeone[4] reported on 2471 injuries to major arteries in the American Armed Forces in World War II. Most were treated by ligation, followed by a 49 per cent incidence of amputation. This rate varied with the artery injured reaching 73 per cent with popliteal artery trauma and 69 per cent if both the anterior and posterior tibial arteries were involved. Only three successful end-to-end anastomoses were done. Of 40 venous grafts by the nonsuture technique, there was success in only 17.

During the Korean War, Hughes[9] reported 269 arterial repairs with 13 per cent amputation. Of those treated by ligation, amputation was necessary in 51 per cent. The popliteal artery was the most critical requiring 32 per cent amputation after repair. Subsequently, higher success rates of direct arterial reconstruction following trauma in civilian life have been reported by Morris, Beall, Roof and DeBakey[12] and Patmon, Poulos, and Shires[16].

Rich and Hughes[18] have a preliminary report of the vascular registry of injuries in Vietnam. Of the initial 500 patients, 66.8 per cent had major arterial injuries; 25.6 per cent had arterial injuries to smaller arteries; and 5.6 per cent were major venous injuries. Ninety-five per cent of their patients reached the hospital by helicopter. The time from injury to operation in most patients averaged 2¾ hours, a vastly different experience from 12 hours in World War II and over nine hours in the Korean War. However, in the Vietnam experience, 159 different surgeons participa-

ted in the surgery. Rich and Hughes[18] considered approximately 28 per cent of major arterial repairs in Vietnam to have been inadequate with an overall amputation rate of 12.7 per cent. Over half of the amputations after unsuccessful reconstruction were popliteal artery injuries.

My personal experience includes that of 23 patients treated at Anniston Memorial Hospital from 1962 to 1969 in whose care I participated as surgeon or assistant. The adjacent table reveals the number of patients, the type of trauma, and the location of the vascular injury. No instance of simple spasm was present in our series. Serious assailants in Alabama apparently use guns in preference to knives, only three vascular knife wounds having been encountered. There were 13 gunshot wounds, including one from a shotgun pumpkin ball, and five close range shotgun blasts. These six wounds required graft replacement. There were associated venous injuries in ten of the 16 arterial wounds, and nine had significant associated neural wounds. In addition, one patient with a gunshot wound of the internal carotid artery was hemiplegic on admission. However, in the ensuing six weeks, the hemiplegia almost completely cleared.

There were two deaths, one early and one late. The early death occurred in a boy of 17 who had a 38 caliber wound of the distal aorta which was treated by resection with reanastomosis. Due to repeated transfusions, the patient became extremely hypothermic. Because of apparent continued shock in the hypothermic state, transfusion was continued, and he died of pulmonary edema 1½ hours postoperative.

A second patient died two months following his initial injury of a shotgun blast of the groin, which included extensive abdominal wounds, multiple bowel perforations, injuries to the iliac artery, and extensive injury to the femoral area necessitating Teflon graft replacement. The boy developed intra-abdominal abscesses and, subsequently, died of complications from these. The arterial graft in the femoral area was functioning satisfactorily, and the lower extremity was okay at the time of death.

A third patient had thrombosis of the external iliac artery following prolonged arterial occlusion because of extensive injury to the internal iliac artery and the external iliac vein with profound shock. His leg survived, but was ischemic necessitating subsequent arterial bypass graft. He is now well.

SITE	KNIFE	GSW	SHOT	BLUNT	TOTAL
1. Carotid Artery		2			2
2. Jugular Vein		1			1
3. Subclavian Artery		1			1
4. Subclavian Vein		1			1
5. Axillary Artery			1		1
6. Brachial Artery			1	1	2
7. Forearm (Both Arteries)				1	1
8. Abdominal Aorta	1	1			2
9. Inferior Vena Cava	1				1
10. Renal Vein	1				1
11. Iliac Artery		1			1
12. Femoral Artery		1	3		4
13. Femoral Vein		3			3
14. Popliteal Artery		2			2
	3	13	5	2	23

Three other patients had extremities of limited usefulness, two upper and one lower, because of extensive neurological damage in addition to the arterial injury. One of these, also, had extensive bone loss at the elbow and edema of the hand due to paralysis from nerve damage and venous insufficiency. This finally required amputation. All arterial repairs or grafts functioned without complication.

One case of Dr. G. O. McGinnis' which deserves special comment is that of a 12 year-old boy who fell from a trapeze at school striking his inner, upper arm on a crossbar. On arrival at the hospital, the patient complained of numbness in the hand. The hand was cool, but did not appear lifeless. There was a small contusion in the skin in the medial upper arm, but no periarterial hematoma. Careful examination, however, revealed the arterial pulsation to stop at the site of in-

jury. At exploration, the patient was found to have circumferential intimal disruption and separation of one centimeter with occlusion. Resection of the afflicted area with end-to-end anastomosis afforded complete recovery. A less astute examiner may well have missed this significant injury.

General Principles of Treatment

Prompt resuscitation is essential. Large venous lines are instilled. If the injury appears to be at the base of the neck or upper thorax, the venous lines should be placed in the lower extremities. Otherwise, upper extremity lines are preferred. One catheter is usually placed in the superior vena cava for subsequent venous pressure monitoring. Shock is initially treated with Lactated Ringers solution plus one unit of Dextran solution as recommended by Hamit.[8] Uncrossmatched blood is given if necessary.

Direct pressure over the bleeding wound is much preferred to tourniquet control if possible. Frequently, the hemorrhage is contained by the vascular sheath causing hematoma formation, but not massive blood loss.

Accurate evaluation of the patient is necessary. Color and temperature of the afflicted area should be noted. Distal pulses should be carefully recorded and evidence of pre-existing vascular disease should be noted. For instance, a patient may have sclerotic vessels and absent distal pulses in the contralateral extremity, as well as, in the afflicted one. The presence of distal pulses does not exclude arterial disruption.[19] Neurological deficit is common, and sensory loss to fine touch may be the first or only sign of vascular insufficiency.[15]

With orthopedic injuries (particularly fracture of the clavicle, supracondylar area of the humerus, distal femur or dislocation in the shoulder or knee) arterial injuries are common. These may be difficult to evaluate because of the bone deformity and massive hematoma formation. In these instances, one should promptly resort to arteriography. With dislocations, prompt reduction may result in restoration of distal pulsatile flow; but after reduction, arteriography probably should be performed.

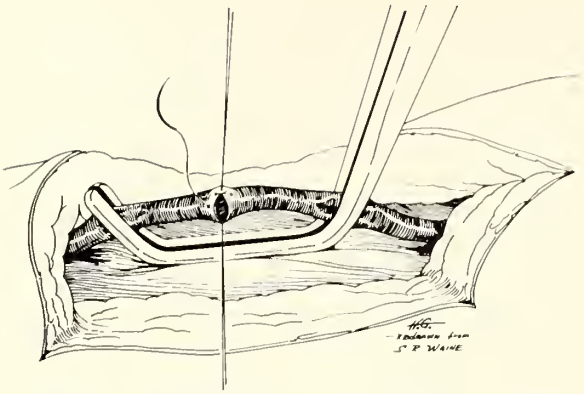
Early exploration should be done in questionable injuries. This includes wounds of the major vascular tracts in which there is reasonable possibility of vascular injury. Liberal use of arteriography is indicated, and may be helpful before surgery or at the operating table.

Preoperative and transoperative antibiotic therapy is given. An agent potent against staphylococcus is desired.

Blood transfusions, if repeated, should be warmed to normal body temperature so that hypothermia does not result. Calcium gluconate should be administered in appropriate amounts. Sodium bicarbonate should be administered if acidosis is suspected, and this includes all patients in shock.

The first operative maneuver is to obtain proximal and distal control; then explore the wound. At times, a proximal tourniquet can be used. Similarly, a distal tourniquet may be useful to obstruct venous return for wounds of the groin and shoulder, if there is difficulty in obtaining adequate venous control. A piece of sterile rubber tubing can be used for this.

With clean wounds and a partially transected artery, simple repair is a method of choice. With bullet wounds or complete severance, usually debridement of a few millimeters of the arterial wall with direct end-to-end anastomosis is preferred. We have no experience with high velocity wounds, but Rich and Hughes[18] recommend resection of at least one centimeter of proximal and distal artery in these cases. With smaller arteries, a highly satisfactory technique is that of Pearlman[17] in which both ends of the artery are held in a single arterial partial occlusion clamp. (Sketch I) Interrupted sutures are then utilized to repair the small artery, while the two ends are held in approximation and perfectly immobile. Grafts will not usually be necessary in civilian practice, unless there is a shotgun blast or a stretch-type arterial



Sketch I. Immobilization of smaller artery for precise repair. (Abstracted from Pearlman[17].)*

injury associated with a fracture or dislocation. High velocity missile wounds may require a graft, also. If it appears that a graft will be likely, an assistant should be taking a length of saphenous vein from an uninvolved lower extremity while the artery is being exposed. If the patient is to be placed in the prone position for exposure of the distal popliteal, then the graft should be taken prior to turning the patient over. Most popliteal wounds can be treated by the medial approach.[7, 20]

Diluted Heparin solution should be instilled in the distal arterial vessel periodically while preparations are made for repair and while the repair is being effected.

If there is an associated fracture, the arterial hemorrhage should be controlled. Tourniquets should be removed. The fracture should be stabilized preferably with plate or nail fixation, so that there will be adequate immobilization of the arterial repair in the postoperative period. After the bone is stabilized, the artery is repaired. Usually, a Fogarty catheter should be utilized to be sure the distal artery is free of debris or clot.

If significant arterial tissue loss is present, vein graft replacement is much preferred to artificial prosthesis because of better ability to withstand infection.

* Redrawn by A. Harry Germagian; Medical Illustrations Soc.: V. A. Hospital; Birmingham, Alabama.

It has been found, with shotgun wounds including extensive muscle damage, as well as vein and arterial injury, there may be profuse bleeding of a nonarterial nature after restoration of distal flow. In this instance, a compression bandage may be necessary to control the venous bleeding, and should be used if good distal pulsatile arterial flow has been properly restored.

Specific Areas

Neck: With injuries to the neck, early endotracheal intubation is the preferred method of treatment. If associated respiratory injury or obstruction necessitates, tracheotomy with a *cuffed* tube is utilized. Exposure should be an anterior sternomastoid incision. An injured external carotid artery is ligated, as is the internal jugular vein. The carotid artery should be repaired using the same deliberation and precision as with repair of any artery. If necessary, resection with end-to-end anastomosis is feasible without bypass shunt, though it may be feasible to use a shunt at the time of correction. CO_2 build-up should be done. Fitchett et al[6] have reported no difficulty with carotid occlusion for up to 90 minutes while repair was being effected.

Base of the Neck: Wounds in the base of the neck should be treated by median sternotomy with extension upward along the sternomastoid, or outward over the clavicle. The medial portion of the clavicle can be resected. This incision can then be extended vertically down the linea alba or transversely through an intercostal space. With an obvious injury in this area, early intubation and very aggressive exploration, even without patient stabilization, should be done.[1] In questionable wounds, arteriography is indicated.[11]

Upper Extremity: Be cautious in exploring the artery because of the adjacent nerves. Injured nerves are left alone at the time of the initial repair, unless a trunk is partially severed by a clean wound. Do not hesitate to take the medial clavicle for better exposure. In general, an injury to either fore-

arm artery, in an otherwise reasonably healthy extremity, need not be repaired. However, if there is doubt, careful repair with interrupted sutures should be made. Fasciotomy in the forearm is frequently necessary.

Abdomen: The hepatic artery probably can be ligated, if the injury is proximal to the gastroduodenal and the other celiac branches are intact. However, if the patient's condition permits, repair can be done. The splenic artery can be ligated with impunity. Accompanying splenectomy is not always necessary, if the injury is proximal. The major superior mesenteric artery should be repaired, but after several branches have come off, this probably can be ligated. The inferior mesenteric artery near its base can be ligated; but observation of the bowel for some time is definitely indicated. The portal vein should be repaired. An injured superior mesenteric vein or splenic vein can be ligated. A nonexpanding hematoma adjacent to the vena cava probably should not be opened, but most caval wounds will require direct repair. Below the renal veins, ligation is an acceptable alternative under duress.

Lower Extremity: Repair in the femoral region is feasible and usually simple. If there is long arterial loss involving the common femoral including its smaller branches, as well as, the deep femoral branch, the replacement is preferably done with a vein graft. The deep femoral branch should, also, be restored in this instance by anastomosing it into the side of the graft.

The popliteal area is most critical in terms of limb loss, if correct judgment and meticulous surgery is not utilized. Extremely early exploration in this area should be done. An injured anterior tibial and posterior tibial artery may be ligated, but if both are disrupted, repair should be effected.[13]

Again, distal fasciotomy is very frequently indicated, particularly with associated extensive venous injury. The anterior compartment in the leg is the area most easily compromised by edema. Difficulty with great toe extension or pain in the area should warrant early fasciotomy.

Veins: In general, the major veins in the extremities can be ligated, if there is still continuity of other venous return. Rich and Hughes[18] recommend venous repair if more than 50 per cent patency can be maintained. In the upper extremity, we would repair a clean wound of the axillary vein, but ligate veins distal to this. Cook and Haller[3] have reported fatal thromboembolism, however, with injuries to the subclavian veins and recommend ligation of these veins if injured. In the lower extremity, our teaching has been to ligate veins distal to the common femoral but repair veins from the common femoral upward.[10]

Arterial Spasm

Arterial spasm is reported to occur not uncommonly, particularly in the upper extremity injuries. With blunt injuries, even with the artery exposed, it is frequently very difficult to differentiate spasm from intimal damage with occlusion and distal spasm. In these instances, aggressive therapy is probably indicated with arteriotomy and dilatation of the distal artery with a Fogarty catheter.[13] With a stretch injury and distal spasm, such as an injury associated with a dislocation or fracture, the entire area which possibly could have been abnormally stretched should probably be resected with a vein graft replacement.[5] The distal arterial tree should be dilated with a Fogarty catheter prior to reanastomosis.

Summary

Our personal experience in a community general hospital with vascular injuries has been reviewed. The treatment of such injuries has been summarized with brief comments on various areas.

Possible vascular injuries should be treated aggressively with accurate diagnosis, prompt resuscitation, and precise repair of injured vessels when indicated. If the patient sur-

vives to receive treatment, salvage of the extremity and life should usually result.*

---

*I am indebted to my associate, Dr. Robert L. Elliott who participated with me in the care of a number of these patients and to Dr. Russell J. Leonard and Dr. G. O. McGinnis for the inclusion of one each of their patients in this series.

References

1. Bricker, Donald L., George P. Noon, Arthur C. Beall, Jr., and Michael E. DeBakey: Vascular Injuries of the Thoracic Outlet. J. Trauma, 10: 1, 1970.

2. Carrel, Alexis and C. C. Guthrie: Uniterminal and Biterminal Venous Transplantations. Surg., Gyn. & Obst., 2: 266, 1906.

3. Cook, Frank W. and J. Alex Haller, Jr.: Penetrating Injuries of the Subclavian Vessels with Associated Venous Complications. Ann. Surg., 155: 370, 1962.

4. DeBakey, Michael E. and F. A. Simeone: Battle Injuries of the Arteries in World War II. Ann. Surg., 123: 534, 1946.

5. Edwards, W. S. and C. Lyons: Traumatic Arterial Spasm and Thrombosis. Ann. Surg., 140: 318, 1954.

6. Fitchett, Vernon H., Marvin Pomerantz, David W. Butsch, Robert Simon, and Ben Eiseman: Penetrating Wounds of the Neck. Arch. Surg., 99: 307, 1969.

7. Gryska, Paul F., R. Clement Darling, and Robert R. Linton: Exposure of the Entire Popliteal Artery Through a Medial Approach. Surg., Gyn. & Obst., 118: 845, 1964.

8. Hamit, Harold F.: Current Trends of Therapy and Research in Shock. Surg., Gyn. & Obst., 120: 835, 1965.

9. Hughes, Carl W.: Arterial Repair During the Korean War: Ann. Surg., 147: 555, 1958.

10. Lyons, Champ: Personal Communication.

11. Monson, David O., Jack D. Saletta, and Robert J. Freeark: Carotid Vertebral Trauma. J. Trauma., 9: 987, 1969.

12. Morris, George C., Arthur C. Beall, Jr., W. R. Roof, and Michael E. DeBakey: Surgical Experience with 220 Acute Arterial Injuries in Civilian Practice. Amer. J. Surg., 99: 775, 1960.

13. Morton, John H., Wheelock A. Southgate, and James A. Deweese: Arterial Injuries of the Extremities. Surg., Gyn. & Obst., 123: 611, 1966.

14. Murphy, J. B.: Resection of Arteries and Veins Injured in Continuity—End-to-End Suture—Experimental and Clinical Research. Med. Record, 51: 73, 1897.

15. Parkes, Athol R.: Traumatic Ischaemia of Peripheral Nerves with Some Observation on Volkmann's Ischaemic Contracture. Brit. J. Surg., 32: 403, 1945.

16. Patmon, D., Ernest Poulos and Tom Shires: The Management of Civilian Arterial Injuries. Surg., Gyn. & Obst., 118: 725, 1964.

17. Pearlman, Donald M.: The Immobilization of Small Vessels to be Sutured. Surg., Gyn. & Obst., 121: 1343, 1965.

18. Rich, Norman M. and Carl W. Hughes: Vietnam Vascular Registry: A Preliminary Report. Sur., 65: 218, 1969.

19. Spencer, Andrew D.: The Reliability of Signs of Peripheral Vascular Injury. Surg., Gyn. & Obst., 114: 490, 1962.

20. Szilagyi, D. Emerick, John G. Whitcomb, Roger F. Smith: Anteromedial Approach to the Popliteal Artery for Femoropopliteal Arterial Grafting. Arch. Surg., 78: 153, 1959.

"The Use Of Locorten (flumethasone pivalate) Cream In The Treatment Of Common Dermatoses"

Paul G. Reque, M. D., and Robert O. Lauderdale, M. D.

Birmingham, Alabama

The introduction of any new topical steroid should be accompanied by clinical evidence that the new product has apparent advantages over topical steroids already in use, and that it should have fewer undesirable side effects. Flumethasone pivalate, to be introduced as Locorten®, has been found to be extremely active in low concentration, as evidenced by measuring the degree of foreign-body granuloma formation, after implantation of cotton pellets under the skin of the back of male rats. Locorten® was found to be 800 times more effective than cortisol acetate, about 70 times more effective than prednisolone pivalate, and ten times more effective than dexamethasone pivalate in inhibiting the granuloma formation.

When sufficient dosage of flumethasone pivalate was used topically to influence inhibition of foreign-body granuloma formation, it was found 80 times this dose was needed to significantly alter body, adrenal, or thymus weight in the same type of rats. This would suggest a great margin exists between clinically effective topical dosage, and dosage sufficient to cause systemic effects.

The clinical formula of flumethasone pivalate, hereafter to be designated as Locorten®, is as follows: 6 alpha, 9 alpha difluro-11 beta, 17 alpha-dihydroxy-16 alpha methyl-21 trimethylacetoxy-1, 4-pregnadiene-3, 20 kione.

The structural formula of "Locorten" is shown in Table I.

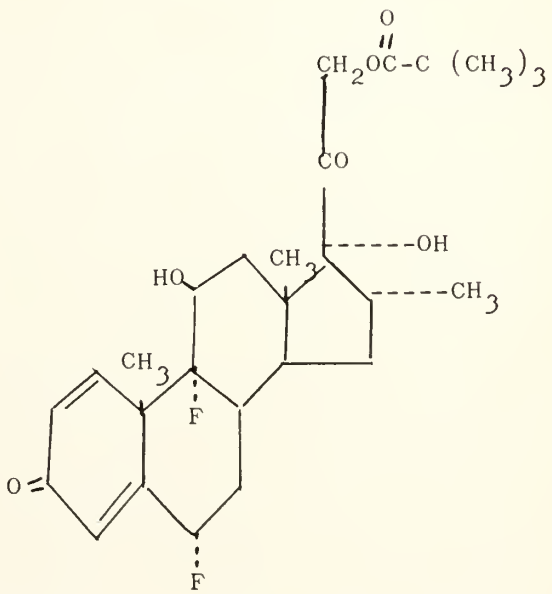


Table 1

Clinical Studies

The preparation used in this clinical trial was a 0.03 per cent Locorten cream* of vanishing type base. It was usually applied to affected areas twice each day, although at times the cream was applied three times daily. Patients were unselected as to age, sex or color, and were treated without concomitant therapy. Table II is a list of the types of skin diseases treated, with the result of such treatment over the period of follow-up, from two days to nine months duration. Patients ranged from nine years of age to 80 years. As much as 150 grams of topical cream was used in one patient without systemic effects being observed. Only routine urine, white blood counts and hemoglobin determinations were performed for each patient at beginning of the clinical study.

Evaluation of Results

All patients were seen by the physician at frequent intervals, usually from one to two-weeks apart. Dermatoses were considered as responding "satisfactorily" if the condition

cleared or was nearly cleared, with full disappearance of symptoms, such as itching, burning, or erythema. Dermatoses which remained unchanged, or only slightly improved symptomatically, or had undesirable side effects, or relapsed promptly upon cessation of therapy were classed as "unsatisfactory."

Clinical Results

As may be seen from Table II, 32 different skin diseases were treated, the majority being the more common dermatoses seen in the general practice of dermatology. An overall average of 92 per cent was considered to have responded favorably to the topical application of Locorten Cream .03 per cent. The prompt disappearance of itching as a symptom, and the generally dramatic clearing of erythema was gratifying to the patients and examiners alike. Certain dermatoses, notably keratoses, onycholysis, acne, and dermatitis herpetiformis, were included if concomitant erythema or swelling was encountered, but "cure" was not expected; simply relief of symptoms. Cosmetic acceptance of the vanishing cream base was excellent, and except for the five patients experiencing mild dryness and irritation, all patients were pleased by the preparation.

Undesirable Reactions

These were few considering the number of patients treated, five (5) of 147 treated. The unsatisfactory side-effects consisted of increased sensations of burning and stinging, with two patients also complaining of a "drying" effect. No systemic ill-effects were recorded, and no positive allergic skin tests were elicited in any of the five patients reporting irritation or burning.

SUMMARY PATIENTS TREATED WITH .03% LOCORTEN CREAM

Diagnosis	No.	RESULTS Satisfactory	Unsatisfactory	Side Effects
Contact Dermatitis	17	16	1	1=burning & stinging
Neurodermatitis	15	13	2	1-irritating 1-burning
Dyshidrosis	13	12	1	0
Nummular Eczema	14	13	1	1-drying
Seborrheic Dermatitis	12	11	1	0
Psoriasis	6	6	0	0
Stasis Dermatitis	5	5	0	0
Eczematoid Dermatitis	5	5	0	0
Intertrigo	4	3	1	0
Rosacea	4	4	0	0
Rhus Dermatitis	4	4	0	0
Pruritus Vulvae	3	3	0	0
Pruritus Scroti	3	2	1	0
Localized Eczema	2	1	1	1-irritating & drying
Folliculitis	2	2	0	0
Atopic Dermatitis	2	2	0	0
Pruritus Ani	2	2	0	0
Cheilitis	2	2	0	0
Photosensitivity	2	2	0	0
Senile Keratosis	1	1	0	0
Erythema Multiforme	1	1	0	0
Lichen Planus	1	1	0	0
Onycholysis	2	1	1	0
Keratosis, Seborrheic	1	0	1	0
Acne	1	1	0	0
Bites	1	1	0	0
Otitis Externa	1	1	0	0
Senile Pruritus	1	1	0	0
Vasculitis	1	1	0	0
Stasis Ulcer	1	1	0	0
Dermatitis Herpetiformis	1	1	0	0
Thermal Burn	1	1	0	0
TOTALS:	132	121	11	1-irritating 1-burning 1-irritating & drying 1-drying 1-burning & stinging
No follow-up:	15			
Totals:	147			

TABLE II

Summary

The introduction of Locorten Cream (flumethasone pivalate) for topical use in miscellaneous dermatoses should add a valuable aid in dermatological therapy. In a total of 147 patients treated with a water miscible vehicle containing 0.03 per cent flumethasone pivalate, 121 responded favorably to its use, 11 were not improved, and 15 patients were lost in follow-up. Five instances of dryness or irritation were recorded, none of which were found to be patch-test positive to the preparation.

Barking Up Wrong Medical Association Tree

The following three letters, from the Journal of the Florida Medical Association, are self-explanatory:

Dear Editor:

The current issue of Reader's Digest contains a gross error. I feel that the Florida Medical Association should protest. "Profiteers Are Wrecking Medicaid" on page 151 lists as an example of a Medicaid profiteer a Florida physician. If Florida has no Medicaid, how can a Florida physician be a profiteer in the system?

William T. Haeck, M. D.
Jacksonville

Mr. Hobart Lewis
President and Editor-in-Chief
Reader's Digest

Dear Mr. Lewis:

We have reviewed the article in the October 1969 issue of the Reader's Digest entitled "Profiteers Are Wrecking Medicaid." On page 152, it states that a Florida physician offered kickbacks to patients if they would cooperate in their being listed on false claims for services he had not performed, and in one instance he claimed 21 house calls or office visits for a patient who was in Greece at the time.

I would greatly appreciate the source of information on which this statement is based, as it reflects upon the physicians of Florida. It would be impossible for there to be any abuse of Medicaid in Florida, as such a program has never existed in this state and has just recently been authorized by our Florida legislature to become effective January 1, 1970.

Legitimate criticism should not be objected to by anyone, but when authors make slanderous unfounded statements, they should certainly be held responsible.

Thank you for consideration of this request.

W. Dean Steward, M. D.
Public Relations Officer
Florida Medical Association

Dear Doctor Steward:

We deeply regret that it was necessary for you to point out that, because Florida has no Medicaid program, the illustration concerning a Florida physician had no place in "Profiteers Are Wrecking Medicaid." The error stems from the fact that one of our researchers found the example in a Washington Post Report (June 15, 1969) on the Senate Finance Committee's investigation of both Medicare and Medicaid, and there, unfortunately, it was cited as an abuse of Medicaid. A further check should have been made.

Thank you for giving us an opportunity to explain.

Hobart Lewis
Pleasantville, N. Y.

Pulmonary Function Testing For The General Hospital and Physician

D. S. Tysinger, Jr., M. D.
Dothan, Alabama

Part V—Maximum Voluntary Ventilation (Maximum Breathing Capacity)

The Maximum Voluntary Ventilation (MVV) is done to find out how much air an individual can move in and out of his lungs by breathing as deep and as fast as he can. This maneuver was once termed Maximum Breathing Capacity. There have been studies done in which the patient was pushed to breathe as deep and fast as he could with stimuli such as increased carbon dioxide in the inspiratory gas mixture and these studies have shown that this volume is not always obtained when the individual breathes as deep and fast as he can. Therefore, the newer term is more descriptive. In making this measurement it is absolutely necessary for the technician to be a "cheerleader" and encourage and push the patient to perform at his best. It is quite difficult for anyone to maintain this deep breathing for any length of time; therefore, it should not exceed 15 seconds.

This is the first test described which does carry some degree of risk. The individual breathing deep and fast causes a certain degree of alkalosis due to an abnormal elimination of carbon dioxide in the process. This usually elevates the blood pressure, both systolic and diastolic, for a temporary period. If this test is being performed by an individual who already has high blood pressure, there is usually an increase in the blood pressure which may be sufficient to cause a stroke. In the individual who may have preexisting poor circulation to the brain there is danger because of the high oxygen levels and low CO_2 levels along with alkaline pH, all of which cause cerebral vasoconstriction. In the individual with an aneurysm this can lead to leakage and rupture of the aneurysm. All of these potential dangers should be considered before a MVV is performed. In the normal individual as a MVV is being performed, the patient will usually breathe quite deep and since he can ventilate 65-70 per cent of his inspired volume in one second, he will ventilate usually to this level and each breath will include the inspiratory capacity and part of the expiratory reserve volume, as noted at A in Diagram 18.

Most spirometers have several kymograph speeds. Both the vital capacity and maximum voluntary ventilation are done at the fastest speed so that the millimeter travel of the recording paper will be relatively large per unit of time. This makes it easier to measure time-volume relationships.

First, there is the individual who has restrictive disease. If it is purely restrictive his curve will look very much like the normal; however, the volume will be smaller. It will be noted in comparing this MVV to the vital capacity that they both are essentially equally reduced as to per cent of normal or predicted volume at B in Diagram 18.

Second, there is the MVV when obstructive disease is present. In these individuals it will be noted that as the MVV is done, it is done with a somewhat faster rate and at a higher level than the normal tidal volume. This patient, in an effort to get maximum elasticity from his lungs and maximum air movement, does not exchange as much volume but does exchange starting at the top of his inspiratory capacity and then breathing out to the point that there is resistance in the tubing due to obstruction. This resistance begins to slow the rate of emptying at which point he takes in the next breath. Thus, he usually breathes at a more rapid rate delivering less

This is the fifth in a series of seven articles.

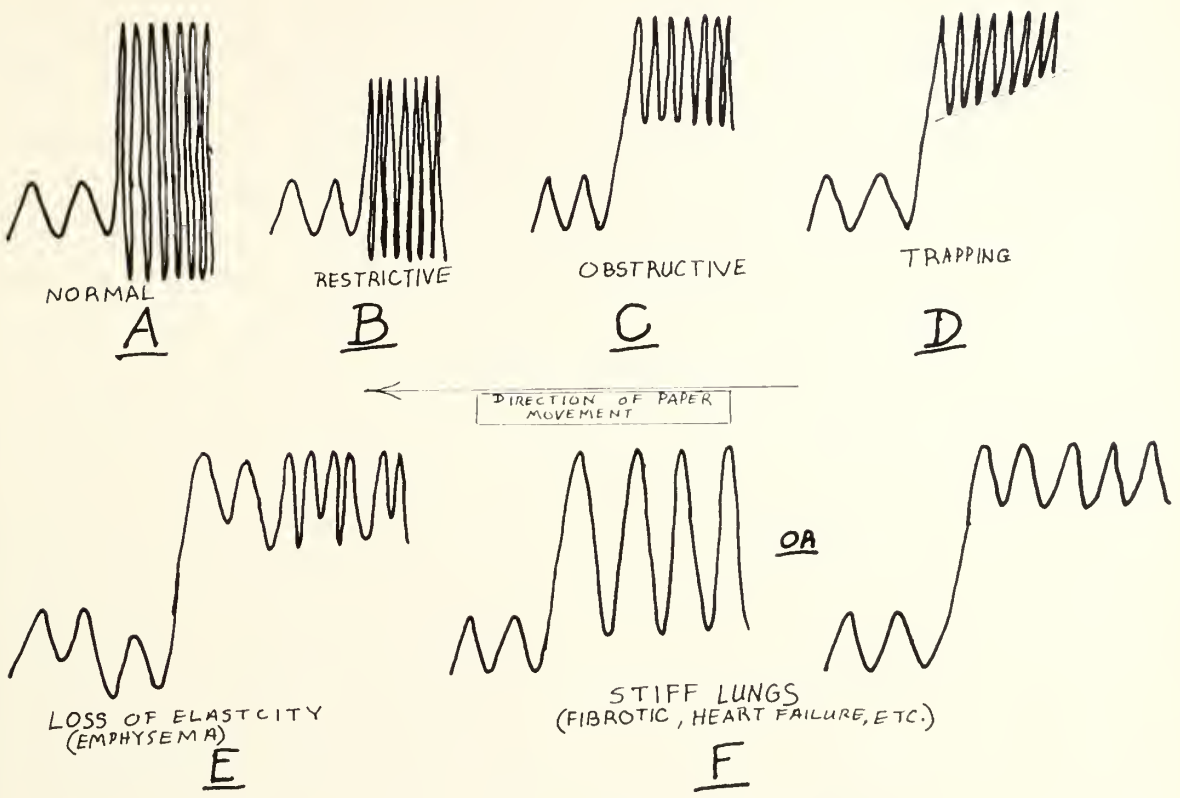


Diagram 18

volume and is usually above the tidal volume line as demonstrated at C in Diagram 18.

Third, trapping is noted in a MVV by the patient taking in and breathing out more air during the first breath than the second as was demonstrated while doing successive vital capacities. The forced breathing at fairly rapid rates causes trapping in these individuals so that each successive breath is slightly smaller than the previous one. This is demonstrated at D in Diagram 18.

Fourth, there is the emphysematous individual or the individual with marked loss of elasticity in whom it is equally hard to move air in and out, particularly at a rapid rate. He usually does this at the top of his vital capacity with irregular depths and irregular rates as he goes about breathing. As a rule he exchanges very little more each breath than he does in normal breathing. Often the vital capacity is very little more than his tidal volume. This individual has lost the responsiveness of his tissue elasticity and, therefore, the chest cage and diaphragm must do practically all of the work by changing the direction of muscular forces with no other assistance. Thus, he has a very slow and irregular pattern as seen at E in Diagram 18.

Fifth, with the stiff and fibrotic lung, as was previously demonstrated with the inspiratory vital capacities, there is flattening of the inspiratory curve as well as the expiratory curve. This individual, when doing a voluntary ventilation, may choose a rather slow rate with deep excursions or an intermediate rate with shallow excursions somewhat similar to the emphysematous pattern. Since there is a restriction on the quick component of breathing, rate and speed are an extreme disadvantage.

The basic patterns have been presented.

The pulmonary functions that have been discussed up to the present may vary 20 per cent either way and still be considered within normal limits. This is a variation from person

to person. However, pulmonary functions done on an individual on successive days and weeks and followed up for a period of several years shows that in the normal there is less than five per cent variation from one test to the next. A pulmonary disease process (be it restrictive, obstructive, emphysematous, or fibrotic), if it is stable, will vary five per cent or less from evaluation to evaluation. If an individual is tested and six months later he is tested again, and if the second testing is found to be ten to 15 per cent worse than during the first testing period, then this does represent a significant change in function and indicates difficulty in the patient though the test may be within normal limits. Pulmonary function studies including vital capacity and maximum voluntary ventilation in an individual will be a good baseline to re-evaluate this patient at a later date if he is developing trouble.

With the functions that have been discussed thus far 80 per cent or better of any of the functions in relation to predicted values for age, height, etc., is considered to be within normal limits. Between 70 and 80 per cent of predicted is considered mild or slight difficulty. Between 60 and 70 per cent is moderate difficulty. From 50 to 60 per cent is severe and below 50 per cent is very severe. Thus, one can look at the various functions that have been discussed to the present and speak of each one as being within normal limits, slight or mild, moderate, severe, and very severely reduced. Likewise, a ten to 15 per cent reduction over a previous testing shows mild increase in abnormality, 15 to 30 per cent reduction is moderate reduction. A reduction over a previous run of 30 per cent or more is a severe reduction since the previous run. This way one can look at previously done function studies and evaluate them so that reports will be comparable when one says that functions are slightly worse at this time than they were a year ago, or moderately worse or severely worse since previous testing. Likewise, where there is rather severe disease, function studies provide a basis to rate improvement. As an example, studies that were severely reduced on a previous run show improvement and are now only moderately reduced. Likewise, if different equipment is used in different laboratories, when the figures are reduced to paper as measurable volumes, then they are comparable. The author's group ran a series of patients on the Jones Pulmonar, Collins 13 liter spirometer and Godart Pulmonet on various occasions and found that the volumes measured—total vital capacities, timed fractions, maximum voluntary ventilation, and flow rates—were quite comparable from machine to machine, all remaining within the five per cent normal variation. There was closer correlation between the Collins and Godart than there was between the Jones and these two. This variation, however, was in the normal range and was insignificant. The difference is related to the automatic temperature correction factor of the Jones Pulmonar. In patients with pulmonary disease, progress of abnormalities showed up equally well from one to the other.

For years pulmonary research workers have looked for didactic figures to put down, a number to indicate a relative situation. The vital capacity and tidal volume have been compared to the MVV in various ways. All of these have been attempts to numerically relate a maximum voluntary ventilation with the vital capacity and tidal volume.

The first of these to be discussed is the air velocity index. Here, the vital capacity is expressed as per cent of predicted; also, the MVV is presented as per cent of predicted. This is thought to show some degree of obstruction or to estimate the amount of obstruction present. The equation for the air velocity index is the per cent of predicted maximum voluntary ventilation divided by the per cent of the predicted vital capacity. (AVI = %MVV/%VC). This is usually 0.8 to 1.0 in the normal. As was previously noted the MVV is lower in the individual with obstruction than is the vital capacity; thus, the per cent of predicted is less. In obstructive disease AVI is below 0.8 and will give

some idea numerically of the amount of obstruction. For example, if the per cent of predicted MVV is 25 per cent and the per cent of predicted vital capacity is 75 per cent, there is severe reduction of one and mild reduction of the other. Twenty-five divided by 75 gives an air velocity index of 0.33. If, however, there is simple restrictive disease in which the maximum voluntary ventilation is 50 per cent of predicted and the vital capacity is 50 per cent of predicted, then there is an air velocity index of 1.0. This is simply a way of relating a maximum voluntary ventilation to the vital capacity.

The capacity ratio is the number of liters of MVV per liter of vital capacity. When this ratio is low it is indicative of obstructive ventilatory insufficiency. When it is normal and both figures are abnormal then it is indicative of restrictive disease. The capacity ratio formula is the maximum voluntary ventilation in liters per minute divided by the vital capacity in liters. Capacity Ratio = MVV L/min./VC L. For example, if the maximum voluntary ventilation is 99 liters per minute, and the vital capacity 3.515 liters, then the capacity ratio is 28.2 liters per minute per liter.

The next index is breathing reserve. This relates MVV to minute ventilation and is a numerical way of evaluating dyspnea. In computing this value one takes the MVV minus the minute ventilation, the latter of which is obtained from the normal breathing pattern and is expressed as the volume of air per breath times the rate per minute. The minute ventilation is subtracted from the maximum voluntary ventilation and the remainder is expressed as a per cent of the maximum voluntary ventilation. The formula for breathing reserve is MVV minus MV divided by MVV times 100 (Breathing Reserve = MVV—MV/MVV $\times$ 100). A normal individual has a breathing reserve of 88-95 per cent. This may decrease somewhat with age. Dyspnea is usually noted when breathing reserve decreases below 70 per cent. To evaluate dyspnea another way the ventilation can be measured while exercising and when exercise reaches that point that the minute ventilation causes a drop in breathing reserve to 70 per cent or below then there usually is dyspnea present.

The other long-standing measurement is that of dyspnea index. The dyspnea index is very simply the minute ventilation expressed as per cent of the maximum voluntary ventilation. The dyspnea index is MV divided by MVV times 100. (Dyspnea Index = MV/MVV $\times$ 100). For instance, if the maximum voluntary ventilation is 100 liters per minute and the minute ventilation is five liters a minute, then five liters divided by 100 liters times 100 gives a dyspnea index of five per cent. Dyspnea Index may also be determined with exercise; when the minute ventilation is 50 per cent or more of the maximum breathing capacity dyspnea is present and work limited.

The important thing is the understanding of the relationships of the minute ventilation and vital capacity to the MVV.

One point should be discussed in relation to measurements based on minute ventilation. When one measures minute ventilation one does not necessarily measure alveolar ventilation. The alveolus and its capillaries are analogous in the lung to the nephron in the kidney. It is the functioning unit within the lung tissue. The tubing and connecting airway are merely passageways for the air to pass through. Therefore, there is in the lungs a portion of the tidal volume or minute ventilation—a portion of each breath —that primarily fills up tubing and passages and does not take part in gas exchange. This is known as the anatomical dead space. Fowler demonstrated a very close correlation between body weight in pounds and ml. of anatomical dead space. If there are areas in the lung which are ventilated but which do not have blood supply or only partial blood supply, they also act as dead space areas and so there is a physiologic dead space. These are usually measured either with a nitrogen meter or an oxygen meter in which a full

breath of oxygen is taken in, is held for a second, and then is blown out, the volumes being measured as the nitrogen meter writes off concentrations. If one took in 100 per cent oxygen, the air filling the dead space comes out showing no nitrogen. Then, as alveolar air begins to egress there is a sudden rise of the nitrogen concentration to 81 per cent. This amount of pure oxygen, up to about half-way the nitrogen curve depending on the slope of the curve and the volume of air expired during this time, gives one the volume of dead space air. The remaining is air in the alveolar area. The same can be done with a CO_2 meter breathing oxygen or room air and then breathing out until the two rise. It has been noted that if one measures oxygen dead space, carbon dioxide dead space, nitrogen dead space, and helium dead space, the dead space for each is somewhat different. These are physiologic measurements and each is a differently diffusable gas. This is important because in ventilation the dead space must be ventilated before alveoli can be ventilated. If an individual has a 200 cc. dead space and a 500 cc. tidal volume and is breathing 20 times a minute, then his minute ventilation is ten liters a minute, four liters of which is dead space ventilation and six liters of which is alveolar ventilation. If this individual is excited and breathing 33 times a minute and only exchanging 300 cc. per minute due to the increase in rate he is still breathing roughly ten liters a minute. However, he now has a dead space ventilation of 6,000 ml. and the alveolar ventilation instead of being six liters alveolar ventilation per minute is only 3,300 cc. alveolar ventilation. These figures alter the evaluation of the tidal volume and minute ventilation in their relation to the vital capacity and maximum voluntary ventilation. Certainly, the individual who is breathing 33 times a minute and exchanging only 300 cc. would have the same dyspnea index and respiratory reserve capacity as would the individual breathing 20 times a minute with a tidal volume of 500 cc. The reduction in alveolar ventilation however would make the individual with the faster rate much more dyspneic at a nearer normal figure for breathing reserve and dyspnea index than is the individual with the slower rate. It is these small points that the individual evaluating pulmonary function studies must understand and take into consideration as he goes about evaluating the tracing.

As was pointed out in the previous discussion on the vital capacity one can test the individual's vital capacity and MVV and then give medications such as bronchodilators and re-evaluate the patient. Here, improvement of over five per cent can be considered as improvement with these various agents. To compare the maximum voluntary ventilation and vital capacity, each pattern has been mentioned previously and the basis for the comparison has been described. In obstructive disease the basic pattern is one of the vital capacity as per cent of predicted being normal or near normal and the MVV being more reduced, the degree of reduction of predicted over that of the vital capacity being an indication of the degree of obstruction. In this individual, if one uses bronchodilators, preferably delivered with a good IPPB machine, the patient must understand and cooperate in treatment. If the vital capacity is normal one may see little or no change in the vital capacity total. If the vital capacity is reduced, one may see some increase in the total vital capacity as airway resistance is diminished. In the timed vital capacity one may see from mild to marked improvement, in the timed fractions FEV 0.5, 1, 2, and 3, and in our flow rates FEF 200-1200 and 25-75. As a general rule, since obstruction does enter as a factor causing resistance toward the end of the vital capacity curve one will see more improvement, as a rule, in the one second than one does in the half second, more improvement in the two second than one does in the one second, and more improvement in the three second than one does in the two second.

In some generally irritating situations in which the whole tracheobronchial tree is affected, one may see essentially the same degree of change in all of the timed fractions,

but this is rare. Usually the greatest improvement is between one and three second vital capacity. In this situation, since the maximum voluntary ventilation is done high up on the vital capacity curve (from maximum inspiration toward tidal volume) and since this area is nearest normal, if the vital capacity total volume is normal, then there is probably no change in the total vital capacity. The MVV will increase in relation to the vital capacity but will not increase as great as will the 1, 2, and 3 second forced vital capacity. Where the vital capacity is reduced, with the latter 50 per cent being more indicative of the obstructive disease than the first 50 per cent, then following bronchodilators it is usually found that the vital capacity will increase towards normal to a relatively greater degree than will the maximum voluntary ventilation.

If there is trapping, and the signs of trapping which were noted in discussion of the vital capacity and maximum voluntary ventilation are noted, there will be improvement to or toward normal depending upon degree of trapping and the ability of medication to alleviate it. Therefore, in obstructive disease with or without trapping, one can look at the studies before and after bronchodilators and get a good idea of approaches to treatment of the patient.

In the patient with restrictive disease, if there is a restrictive element that can be improved or if there is a degree of obstructive disease also present as there frequently is then improvement may be seen following bronchodilators. This is usually equally effective both with the vital capacity and the MVV. If there is moderate amount of obstructive disease being masked by the restrictive element, one will frequently see a "before treatment" pattern of vital capacity and MVV being equally reduced. However, following bronchodilators, there is relatively little change in the MVV but the vital capacity is improved. Thus, the obstructive pattern is better seen and the difference between vital capacity and MVV will be noticed.

In the emphysematous individual with the loss of elasticity, as this is done, if there is an obstructive element present improvement may be seen. As a rule, if there is no obstruction, there is little change and the pattern of the loss of elasticity shows a rather flat slow descent of the forced vital capacity curve. With these individuals the rate at which muscle change can occur, and the necessity for this to occur before breathing can be accomplished, usually causes both vital capacity and MVV to be severely reduced but as a rule the MVV is more reduced than is the forced vital capacity. As previously stated, there is little change with bronchodilators. However, from clinical experience these patients do improve symptomatically and complaint-wise if they are placed on chronic bronchodilator therapy.

Finally, there is the stiff lung, as seen in the fibrotic, heart failure, or increased surface tension situation. It is noted that the expiratory forced vital capacity in this individual may resemble either the restrictive pattern or more likely may be between the restrictive and the loss of elasticity patterns. The effect on inspiratory flow rates does slow the rate at which the individual can perform in maximum voluntary ventilation so that one has a rather slow rate with fairly good exchange. The forced vital capacity usually is about the same as the forced inspiratory vital capacity and the combined vital capacity unless there is a degree of obstruction due to underlying disease processes. Here again, one can add to the inspiratory vital capacity by doing a three-stage test. Following the first trial give the patient IPPB with nebulization of just water. If the stiffness is due to heart failure and pulmonary congestion there will be improvement due to the transfer of fluid from the pulmonary circuit to the systemic circuit with a reduction of stiffness of the lung. In these individuals following this treatment both inspiratory and expiratory vital capacity will show improvement as will maximum voluntary ventilation both in rate and in depth. The individual who shows the same curve

following this treatment is then given a 15 minute treatment period of Ethanol and Racemic Epinephrine in the nebulizer and, if there is a surface tension problem one sees improvement in the inspiratory vital capacity and possibly some in the forced expiratory vital capacity. Here, again, one sees a reduction in the resistance to inspiration which allows an increase in rate and of maximum voluntary ventilation with an increase in volume as well as usually an increase in volume per breath. In these patients one can attribute the stiffness to surface tension type problems and treatment here is obvious. In those individuals where both of these maneuvers leave the "before treatment" and "after treatment" measurement the same there is conclusive evidence that this is just a stiff fibrotic lung from whatever the cause.

With the tidal volume, with the various forms of vital capacity, with the maximum voluntary ventilation repeated following various forms of treatment with IPPB and water, and with bronchodilators in Ethanol solutions one can now evaluate obstructive disease, trapping, restrictive disease, and compliance problems (so-called stiff lungs) with good indications as to their origin and their sensitivity to treatment by conventional means.

Abuse Of Drugs Scored In Paper Before Maine Association

". . . There has developed a considerable degree of poor prescription habits on the part of physicians in this country . . . Widespread interest in the development of adverse effects to drugs has added to the pressure to do something about the use of drugs since it is now evident that serious and disabling illnesses have resulted and are continuing to result from what oftentimes proves to be abuse of drugs. This latter situation not infrequently ends up in serious legal complications which can prove devastating to the individual physician but also has ramifications as far as all medical practice is concerned. . .

". . . Important factors: (1) it is absolutely imperative that the physician know his drugs well; (2) every physician must consider that the more drugs that any one individual gets at any one time, the greater is his possibility of developing an adverse effect; (3) drugs given in large amounts and continued over long periods of time are most likely to cause some type of adverse effect. . ."

These direct quotes are from a paper by Dale G. Friend, M. D., titled "Useless Drugs, Preparations and the Prescription Fallacies of Physicians," read before the 116th annual session, Maine Medical Association, and published in The Journal of the Maine Medical Association. The paper explored generally such subjects as "Anti-Angina Agents," "Antihypertensives," "Peripheral Vasodilators," "Respiratory System," "Central Nervous System," "Gastrointestinal Tract Drugs," and "The Urinary Tract."

Under "Respiratory System," Dr. Friend declared: "One of the most abused areas of drug therapy occurs in this field. The constant droning into our patients about the virtues of various types of medicine for the treatment of head colds and upper respiratory infections in television advertising as well as advertising directly to the public of various popular magazines, oftentimes done by old and distinguished pharmaceutical firms has brought about a great deal of confusion and abuse of drugs in this field. The use of antihistamines, vasoconstrictors, sedatives and analgesics all in one capsule or tablet is indeed to be deplored." He went on to point out that this combination of drugs can be extremely harmful.

(Paraphrased from the November issue of The Journal of The Maine Medical Association)



PROTEIN CONTENT / 7 oz. Serving*

Bean with Bacon	6.8	Green Pea with Ham (Frozen)	7.6
Beef	8.0	Hot Dog Bean	8.4
Chicken Broth	5.5	Pepper Pot	6.1
Chicken 'N Dumplings	5.8	Split Pea with Ham	10.2
Chili Beef	6.2	Vegetable Beef	5.0
Green Pea	6.9	Vegetable with Beef (Frozen)	5.4

When protein is the focal point in your patients' special diets, Campbell's Soups can be a convenient supplementary source of that essential nutrient.

* From "Nutritive Composition of Campbell's Products" which gives values of important nutritive constituents of all Campbell's Products. For your copy, write to Campbell Soup Company, Dept. 365, Camden, New Jersey 08101.



There's a soup for almost every patient and diet ...for every meal and, it's made by Campbell

Pro-Banthine® Helps...

propantheline bromide

...REVEAL the ulcer

...HEAL the ulcer

The efficiency of Pro-Banthine—its favorable balance of therapeutic and secondary actions—has been thoroughly tested and observed. This quality has been demonstrated surgically, roentgenographically, cinegastroscopically and, above all, clinically.

When physicians needed to relax the restless duodenum for the recently refined technic of hypotonic duodenography they logically turned to Pro-Banthine.

For years Pro-Banthine has been the most widely used anticholinergic medication for calming the gastrointestinal tract—for suppressing secretion, prolonging the action of antacids and providing the proper environment for healing peptic ulcers.

These established therapeutic actions make Pro-Banthine particularly useful in:

- peptic ulcer
- gastritis
- diverticulitis
- irritable colon
- biliary dyskinesia
- functional hypermotility

We wish to thank Drs. Marcia K. Bilbao, Louis H. Frische, Josef Rösch and Charles T. Dotter for this exceptionally graphic example of hypotonic duodenography.

Contraindications: Glaucoma, severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly men with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

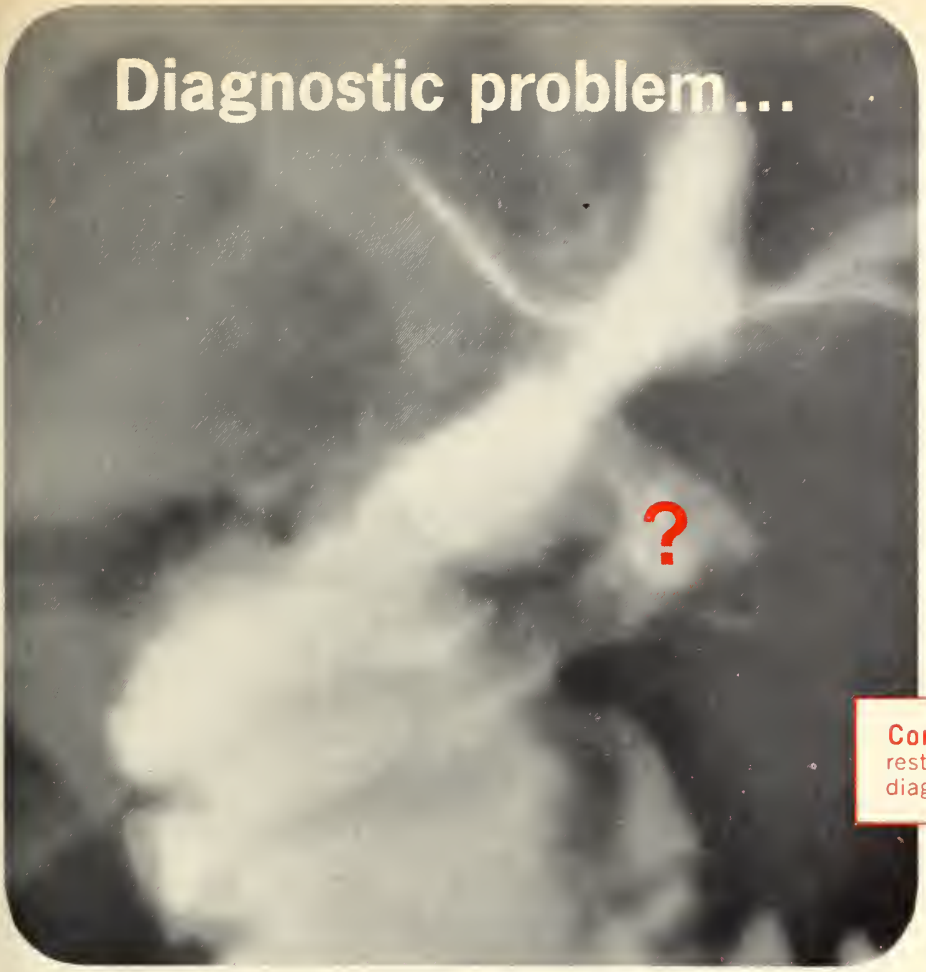
Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal dosage tolerated without excessive side effects is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two 15-mg. tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

982

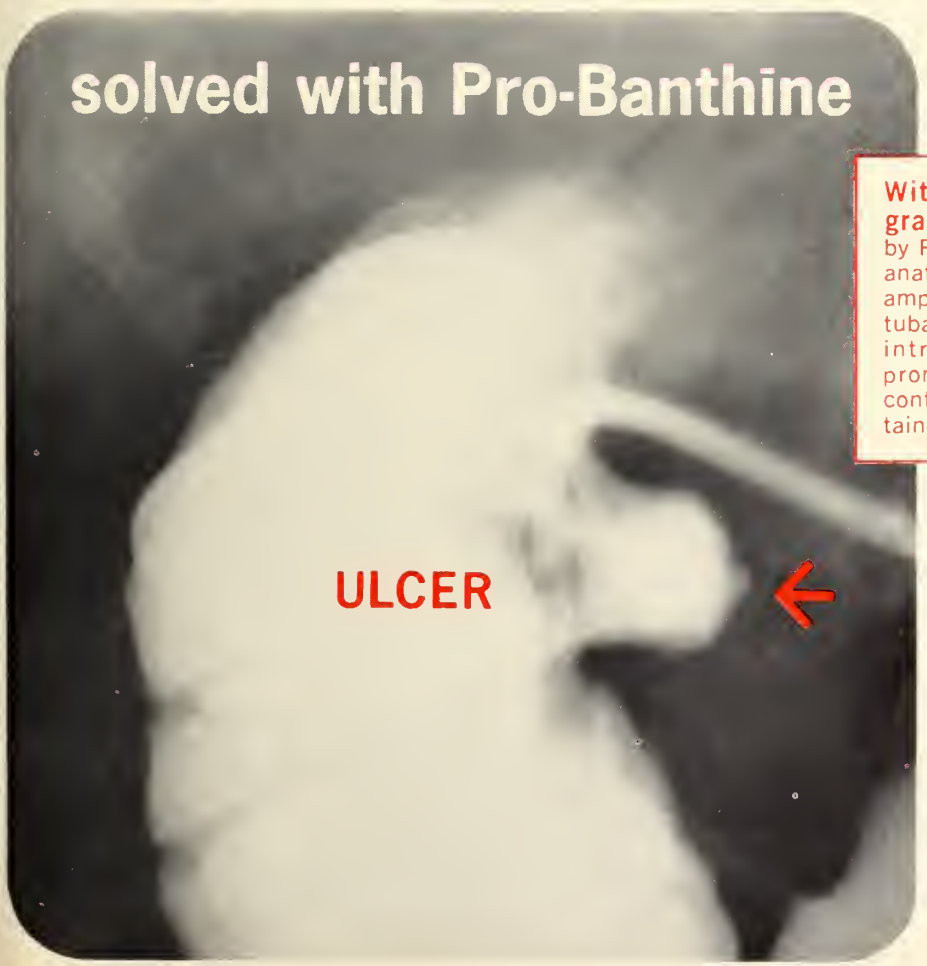
SEARLE *Research in the Service of Medicine*

Diagnostic problem...



Conventional x-rays of the restless duodenum are often diagnostically indefinite.

solved with Pro-Banthine



With hypotonic duodenography duodenal calm induced by Pro-Banthine permits clear anatomic appraisal. In this example the duodenum was intubated. Pro-Banthine, 60 mg. intramuscularly, produced prompt aperistalsis. Double contrast visualization was obtained with barium and air.



Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS

Hobbies To Fill A Doctor's Leisure

Physicians In Pursuit Of Postage Stamps

A tiny rectangle of gummed paper, capable of carrying a thousand times its own weight across town or around the world, is the object of intensive search by some Alabama doctors.

The pursuit may remind one of the doctor's way of chasing one-celled animals across an oiled slide. The difference is that one is work, the other play; one a vocation, the other a hobby.

The label for philately, "hobby of kings and king of hobbies," is of recent origin, almost as recent as the pre-pay postage stamp itself. The first of these stamps came out of England dated May 6, 1840, followed seven years later by the United States and several other countries.

Two of the most famous philatelists of all time were the late King George V and President Franklin D. Roosevelt. In fact, the year of Roosevelt's death the Republic of Nicaragua actually issued a four-cent memorial stamp showing the late President of the United States studying a stamp under a microscope.

Stamps today have become so numerous that all serious philatelists have had to restrict their collections to one or another facet of it, a fact best illustrated by a stamp album just issued under the imprint of Minkus Publications of New York (116 West 32nd Street, New York 10001), titled *Medicine on Stamps*. The author is Joseph H. Kler, M. D., and it is priced at $10.

Dr. Kler, an ophthalmologist-otolaryngologist, has assembled a collection of "Medicine on Stamps" consisting of more than 16,000 stamps in 44 volumes, which he has given to the Cardinal Spellman Philatelic Museum at Regis College, of which he is a founder. His book presents highlights of his collection, ranging from Egyptian Medicine (with Amenhotep, Imhotep, Thoth, and Hathor) to Modern Medicine (Public Health: Poliomyelitis and Nutrition, Maternal and Child Care), from Greek and Roman Medicine, Medicine of the Ancient Jews and Arabian Medicine, to Medical Sidelights (including such subjects as Pope John XXI, Belgian Queen Elizabeth, Florence Nightingale, Clemenceau, Sun Yat-Sen, William Henry Harrison, Empress Catherine II and Paul I), from Medicine in the Renaissance, 16th, 17th and 18th Century Medicine to the 19th and 20th Centuries, with such specialties as Ophthalmology and Otolaryngology, Organic Chemistry, Anesthesia, Bacteriology, Pathology, Antiseptic Surgery, and all the rest.

* * *

Norman Van Wezel's interest in philately began in the months before the market crash of 1929 when he was confined to bed for a prolonged illness. "It really started," he writes, "because of the need for diversion, and company. As soon as my friends knew that I was collecting stamps, I received all of their envelopes that came from foreign countries, especially during the holidays. It was fascinating and educational."



Dr. Van Wezel

Born Jan. 11, 1909 in New York City, the future Dr. Van Wezel spent his childhood in Cleveland. He received his M.D. degree

from Western Reserve in 1935, and came South three years later to become director of the T. B. center in Montgomery. In 1941 he entered private practice in Montgomery, continuing here until he moved to Foley in 1948, where he was active as a specialist in internal medicine and allergies until his retirement for health reasons last June. In 1938 he started limiting his collection to U. S. stamps. Later it was further limited to unused blocks of four. Increasing practice cut his time short until his retirement. He was "merely collecting."

"Now that I am on forced retirement, I have a most fruitful and joyous task ahead: —to arrange, study and mount the collection, for in these last 30 years I have not missed buying each new stamp. Thus grew my interest in philately, and now my renewal of that interest.

Dr. Van Wezel is married to the former Hannah Waxman of Cleveland, a graduate nurse. Their two daughters are: Miss Patricia Van Wezel, librarian at Georgia Tech, and Mrs. Elizabeth Powell (John) of Cheshire, England.

* * *

The interest of Carl F. Dietz, M. D., in philately began in his grammar-school days, continued through student days at the University of Alabama, from which he graduated with his M.D. degree in 1946, and his enthusiasm has remained undiminished to today.

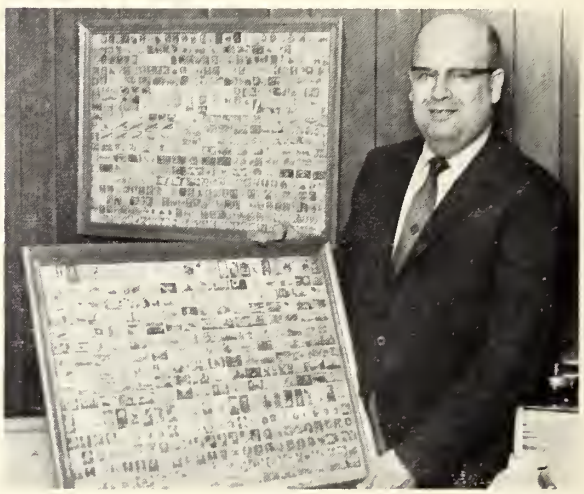


Dr. Dietz

Born in Birmingham April 25, 1933, Dr. Dietz is married to the former Elizabeth Blair, also of Birmingham. And they have three daughters who, hopefully, may share their father's absorption with philately: Elizabeth Carol, 14; Cynthia Ann, 13; and Melissa, 1 year old.

Dr. Dietz interned and also had his preceptorship in surgery in Jacksonville, Fla. From 1948 through 1950 he was in general practice in Gadsden, and served in the U. S. Army in Germany, 1951-53. Since March, 1953, he has been in private practice in Wylam, a Birmingham suburb.

* * *



GILBERT MAY KINZER, M. D. with cases of his postage stamps that hang on his office wall.

When Dr. Gil M. Kinzer of Huntsville first began collecting stamps a dozen years ago, his children were too young to be interested in it. But he began it as an avocation that might in time attract the entire family. Today the family collection fills some 60 albums and several file cabinets, and his son "Butch," presently a freshman at the University of Texas, is the one primarily interested in it.

A native of Huntsville, Dr. Kinzer received his M.D. in 1947 from the University of Tennessee, and except for Navy duty in the Korean War has been in general practice in his native Huntsville since 1950. Presently Dr. Kinzer is secretary of the Section on General Practice of the Southern Medical Association.

* * *

Two Birmingham doctors, dermatologists who share the same office, also share an enthusiasm for stamps, though they classify themselves as casual collectors: "We pick up stamps as they come to us, purchasing some plate blocks as they appear on the American postoffice scene."

Senior of the two is Paul Gerhard Reque, born in New York in 1907, receiving his M.D. degree from Duke in 1934. Dr. Reque is married to the former Barbara Britton,



Dr. Reque



Dr. Lauderdale

Ohioan, and they have two children, a son Peter who lives in California, and a daughter Susan (Mrs. Larry Aldridge), Birmingham.

Dr. Reque's partner is Robert Ottis Lauderdale, Jr., M.D., born in Birmingham Dec. 28, 1924, his degree in medicine from the University of Alabama School of Medicine dated 1949.

Dr. Lauderdale is married to the former Barbara Jones of Birmingham, and they have two sons, Bobby, Jr., and Jimmy; and three daughters, Libby, Laura and Lynn, ranging in age, and in that order, from 17 down to 2.

* * *

Paul Stahl Mertins, Jr., M.D., the son and grandson of a doctor, came by his interest in stamps naturally. His father before him was an enthusiastic philatelist. The current Dr. Mertins, ALR (for Allergy, Laryngology, Rhineology) was born in Montgomery Dec. 14, 1907, attended Barnes School, Washington & Lee (for his baccalaureate), and Columbia (for his M.D.).



Dr. Mertins

Married to the former Anne Moss of Birmingham, there are five children: Anne (Mertins) McDowell, Newport, R. I.; Ellen, 23, a graduate student at Tulane; Marjorie, 21, a senior at the University of Denver; Scott, 19, a freshman in architecture at Auburn; and Lee, 15, now in the Montgomery Academy. Dr. and Mrs. Paul Mertins also have a grandchild, Ellen, now 1 year old.

Dr. Mertins delights in the stamps themselves, "no rare or expensive items, but we have been fascinated by the historical significance of some of them. The commemoratives, the most beautiful historic record of America; a Wells Fargo stamp that was delivered by pony express; a few pictures of Jefferson Davis, memories of the tragedy of the Confederacy; many stamps representing our love and admiration of the character of Washington; finally, frightening in our day, a five-million-mark German stamp," to which Dr. Mertins added: "Let's hope that General Blount never has to go that high."

* * *

And for another of those responding to the MD request for doctors with stamps for a hobby, there is William Lannan Poole, M.D., of Birmingham, where he was born August 12, 1910.

Dr. Poole received his baccalaureate degree from Birmingham-Southern in 1930,

his M.D. from Tulane, and later his Master's from Wayne State University of Detroit. He first became interested in stamps at the age of 16, and subsequently sold a part of his earlier collection to help defray expenses in college.

Dr. Poole is married to the former Mildred Redmond of Birmingham and they have two children: Martha Jane (Poole) Yielding and William L. Poole, Jr., M.D., both of Birmingham.

* * *

The latter two doctors, Paul S. Mertins, Jr., and William L. Poole, will be featured in Fathers-and-Sons-in-Medicine in an upcoming issue of the Journal of the Medical Association of the State of Alabama.

* * *

An interest in stamp collecting for Dr. Quentin R. Strong, Montgomery general practitioner, dates from childhood in his native Birmingham, where he was born June 6, 1921. And now that his three children are growing up, they too have developed an enthusiasm for it.



Dr. Strong

Dr. Strong lives up to his given names—Quentin Roosevelt—aptly, with a record of 15 combat missions over enemy territory in Europe, as a navigator in the 15th Air Force in Italy. His higher education began at Auburn, continued at the University of Alabama, Tuscaloosa, and concluded in 1951 when he received his M.D. degree from the Medical College in Birmingham.

Dr. Strong is married to the former Doris Brett of Robertsdale, and there are three children: a son Henry, now a senior in accounting at the University of Alabama; a younger son George, presently a freshman in medicine at the University of Alabama School of Medicine; and a daughter Elaine, a 10th grader at the Montgomery Academy.

Tobacco Industry Faces Long Overdue Controls

. . . The tobacco industry has done nothing to create sympathy for itself as long-overdue controls . . . loom on the horizon. Although in 1965 they agreed to self-regulation of cigarette advertising to avoid appealing to young persons, refrain from presenting cigarette smoking as a means to social acceptance, and stop other abuses, it was recently revealed that any semblance to self-regulation was stopped more than a year ago . . .

This, as well as the fact that whatever review they did carry out was never recognizable in significantly changed content of commercials, came as no surprise to anyone who owns a television set. Last year the FTC denounced the industry for planting in *True* Magazine an article questioning that smoking is a cause of cancer, then promoting it surreptitiously by newspaper advertising. To keep American smokers spending $9 billion annually on cigarettes, tobacco companies spend more than $300 million yearly on advertising, more than 80 per cent of it on television and radio . . .

In addition to personal efforts with their own patients and support of organized efforts to combat smoking, physicians as citizens can make their voices heard at all levels of government in favor of legislation and social action against the cigarette menace.

Action against this most serious health hazard is as logical as laws regarding pasteurization of milk or purification of water. A concerted multiphasic effort is necessary to counteract the continued promotion of a death-dealing habit, but progress is being made.

—from an editorial in Medical Digest



The Month in Washington

From the Washington Office
American Medical Association

The Nixon Administration called for limitations on medicare and medicaid reimbursements to physicians and hospitals.

Health, Education and Welfare Under Secretary John G. Veneman told the Senate Finance Committee that, because of rising costs, "it is now time to make some fundamental changes in the law which governs medicare and medicaid reimbursements." He said the reasonable cost and reasonable charge criteria in the medicare law had not provided opportunity for major cost-control efforts.

"We need an incentive system of institutional reimbursement and we need changes in the law that will help control the increases in the amount that the medicare program will recognize in the charges of individual practitioners . . .

"I believe . . . that the law should be changed so as to limit further the rate at which increases in physicians fees would be recognized by medicare. The basic difficulty at present is that despite the improvements which have been made in applying reasonable charge guidelines, the best that can be done under present law is to introduce a lag in the recognition of fee increases . . .

"Customary and prevailing charges under the program and the fees recognized by the carriers under comparable circumstances in their own business reflect, in the long run and after a suitable lag in recognition of fee increases, whatever physicians choose to charge the public generally in a market where growing demand is pressing increasingly on the limited supply of health personnel.

"Reliance on Blue Shield fee schedules as the limiting factor in medicare reimbursement, as suggested in the Senate Finance Committee staff report, however, would not seem to us to have long-run viability. Tying payments under a program as large as medicare to Blue Shield schedules would surely exert a major upward pressure on those schedules . . .

"We believe that it is necessary to move in the direction of an approach to reasonable charge reimbursement that ties recognition of fee increases to an index.

"Under such an approach, allowable charges recognized for medicare would next be generally limited to either presently recognized charges or to a new prevailing level set at the 75th percentile of 1969 average customary charges for a given service in an area. In the future the prevailing charge screen would move upward only in proportion to increases in an index made up of pertinent portions of wage and price indices. Under such an approach, recognition of fee increases would continue, but only in relation to things that are happening in other parts of the economy and that have a bearing on the physician's cost of doing business."

The American Medical Association said that any proposal for further limitations on physicians' fees under the government programs would be unwise.

"For all practical purposes, a freeze on physicians' fees under the two federal programs has been in effect for more than a year and has proven to be ineffective," Gerald D. Dorman, M.D., AMA President, said. "The costs of the program have continued to rise in spite of the freeze.

"Physicians are disturbed by threats of additional federal controls.

"Burdening these busy doctors with more red tape and restricting payments to unrealistically low levels may drive them away from participating in Medicare and Medicaid. Then the government will have discriminated against many people who need medical care . . .

"The national interests would be better served if everyone joined with the American Medical Association in its efforts to provide more physicians."

* * *

The National Society for Medical Research said that no valid finding on the effects of marijuana can be expected for another two to seven years.

Science Research Society said part of the difficulty is there is no standard yardstick for evaluating marijuana in scientific studies. The basic weed from which marijuana is made can vary from plant to plant and from country to country, the group said.

But the Society cautioned in a statement: "Until scientifically proven results are obtained, it appears as foolhardy to smoke marijuana as it would be to take any other unknown drug or chemical agent just for kicks."

The Society said two projects are now going on in an effort to achieve scientific standardization in marijuana studies.

* * *

The federal government has negotiated new agreements with France and Turkey aimed at stemming the flow of heroin into this country.

But, in announcing the agreements, John E. Ingersoll, director of the Bureau of Narcotics and Dangerous Drugs, said the government's long-range objective in dealing with the problem is "to induce the medical community to find adequate substitutes" for opium, from which heroin is derived.

Ingersoll admitted the U.S. was asking a great deal of Turkey where opium has been grown for centuries.

"But when you've got over 900 deaths last year from heroin, 224 of them teenagers, in one city, I think you've got a right to start hollering," he said. "There have been three deaths a day for heroin in New York City this year. It is the major cause of death for 18 to 35-year-olds in New York City."

Ingersoll estimated 80 per cent of the 2.5 to 3 tons of heroin smuggled into the U.S. annually comes from the poppy fields of Turkey via the clandestine laboratories of France where the opium is refined into heroin.

The agreement with Turkey includes a $3 million loan approved by the agency for international development in 1968. The money is to be used partly to help the Turks substitute crops like sugar beets and sorghum for opium and partly to equip and train a 460-man narcotics police force.

The U.S. agreement with France calls for frequent exchange of meetings in Washington, D.C. and in Paris to exchange information on such matters as the known drug traffickers and trafficking routes.

France also has assigned a force of 300 police to fight narcotics internally and 30 police to combat it at the international level. Ingersoll's narcotics bureau will increase its manpower in France next year and also will engage in a crosstraining program with French police.

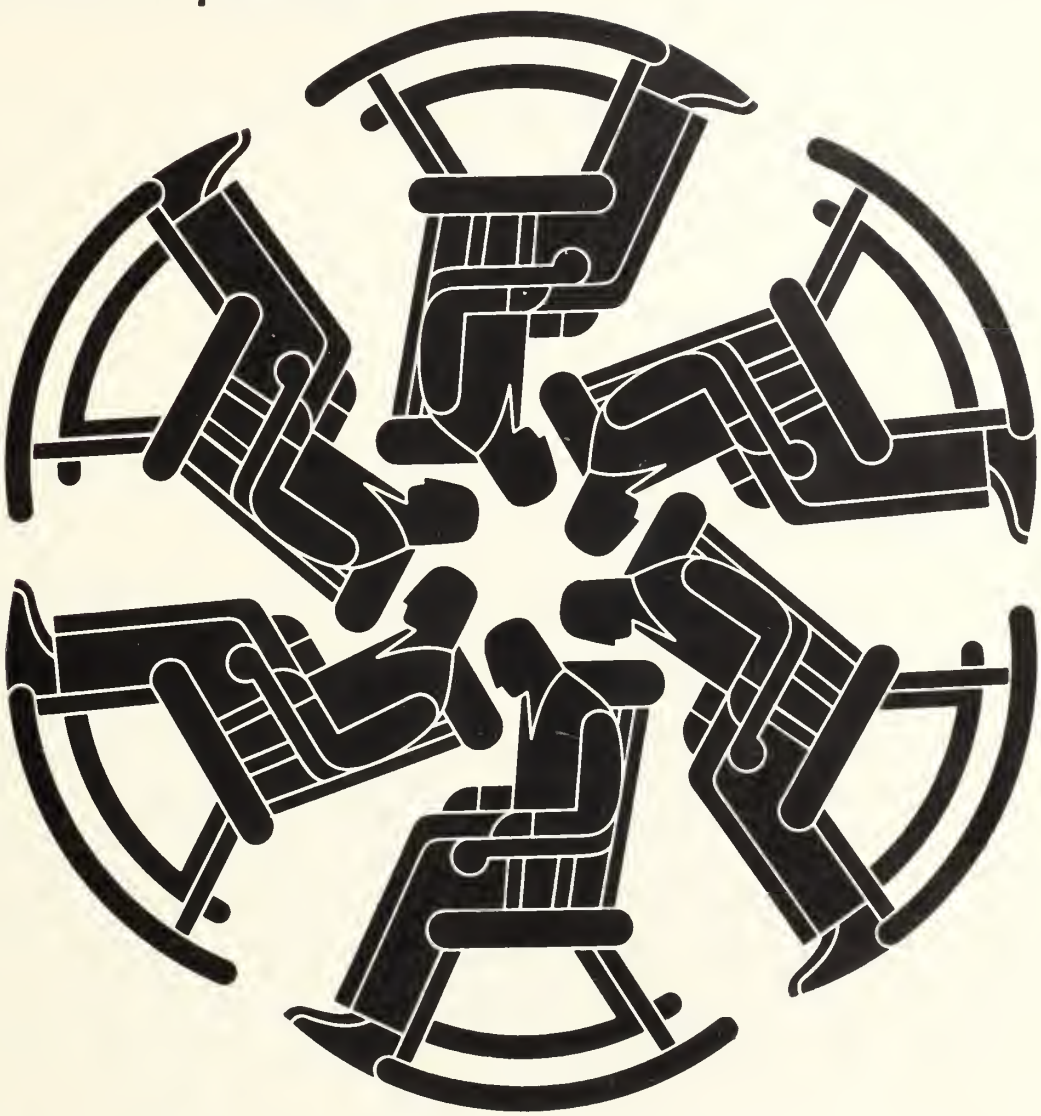
* * *

Congress finally approved an appropriation bill acceptable to President Nixon to provide funds for the Health, Education and Welfare and the Labor departments for the 1970 fiscal year which began last July 1.

The two departments operated under stopgap Congressional resolutions while Nixon and Congress battled over how much money the bill should provide. The Presi-

(Continued on Page 940)

for the debilitated geriatric patient



Berocca®

TABLETS
high potency B-complex and C
for nutritional support

AVAILABLE ONLY ON Rx

contains water-soluble vitamins only

b.i.d. dosage

good patient acceptance

no odor, and virtually no aftertaste

Each Berocca Tablet contains:

Thiamine mononitrate	15 mg
Riboflavin	15 mg
Pyridoxine HCl	5 mg
Niacinamide	100 mg
Calcium pantothenate	20 mg
Cyanocobalamin	5 mcg
Folic acid	0.5 mg
Ascorbic acid	500 mg

Usual dosage is one tablet b.i.d.

Indications: Nutritional supplementation in conditions in which water-soluble vitamins are required prophylactically or therapeutically.

Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B_{12}.

Dosage: 1 or 2 tablets daily, as indicated by clinical need.

Available: In bottles of 100.

ROCHE

Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

(Continued from Page 938)

dent vetoed the first bill passed by Congress on the ground that it would be inflationary because it exceeded his budget by $1.2 billion. Congress sustained the veto but still refused to go all the way with Nixon in cutting funds for the two departments. The second bill totaled $19.4 billion, $680 million more than the President requested. But Nixon accepted the compromize amount when Congress added a provision authorizing him to withhold two per cent of the funds.

The second bill had $176 million in Hill-Burton hospital funds, compared with $258 million in the vetoed measure. The appropriation for health facilities, educational research and libraries was cut from $149 million to $126 million.

Health manpower direct loan funds remained the same, $234.5 million, but an administration spokesman said it was planned to withhold $15.5 million. Other announced plans to withold funds in the health field included:

—$6 million from $108.8 million for air pollution control;

—$6.3 million from $35.5 million for construction of community mental health centers;

—$6.3 million from $360.3 million for mental health programs;

—$8.7 million from $146.3 million for the National Institute of Arthritis and Metabolic Diseases;

—$5.7 million from $107 million for the National Institute of Neurological Diseases and Stroke;

—$1.3 million from $103.7 million for the National Institute of Allergies and Infectious Diseases;

—$10.3 million from $164.6 million for the National Institute of General Medical Sciences;

—$7 million from $76.6 million for general research and services.

* * *

The Food and Drug Administration announced plans to require that a warning leaflet be included in every package of birth control pills.

"I have come to the conclusion that the information being supplied to the patients in the case of the oral contraceptive is insufficient and that re-evaluation of our present policies is in order," FDA Commissioner Charles C. Edwards, M.D., told the Senate Monopoly Subcommittee at one of its public hearings on side-effects of birth control pills.

A proposed draft of the warning leaflet states that "there is a definite association between blood-clotting disorders and the use of oral contraceptive."

It emphasizes the importance of reporting any side-effects to "your doctor."

"All of the oral contraceptive pills are highly effective for preventing pregnancy, when taken according to the approved directions," the proposed draft says. "Your doctor has taken your medical history and has given you a careful physical examination. He has discussed with you the risks of oral contraceptives and has decided that you can take this drug safely.

"This leaflet is your reminder of what your doctor has told you. Keep it handy and talk to him if you are experiencing any of the conditions you find described . . .

"Besides women who have or who have had blood clots, other women who should not use oral contraceptives are those who have serious liver disease, cancer of the breast or certain other cancers and vaginal bleeding of unknown cause.

"If you have heart or kidney disease, asthma, high blood pressure, diabetes, epilepsy, fibroids of the uterus, migraine headaches, or if you have any problems with men-

(Continued on Page 943)

vacation in
a vial:
the spasm
reactors
in your practice
deserve



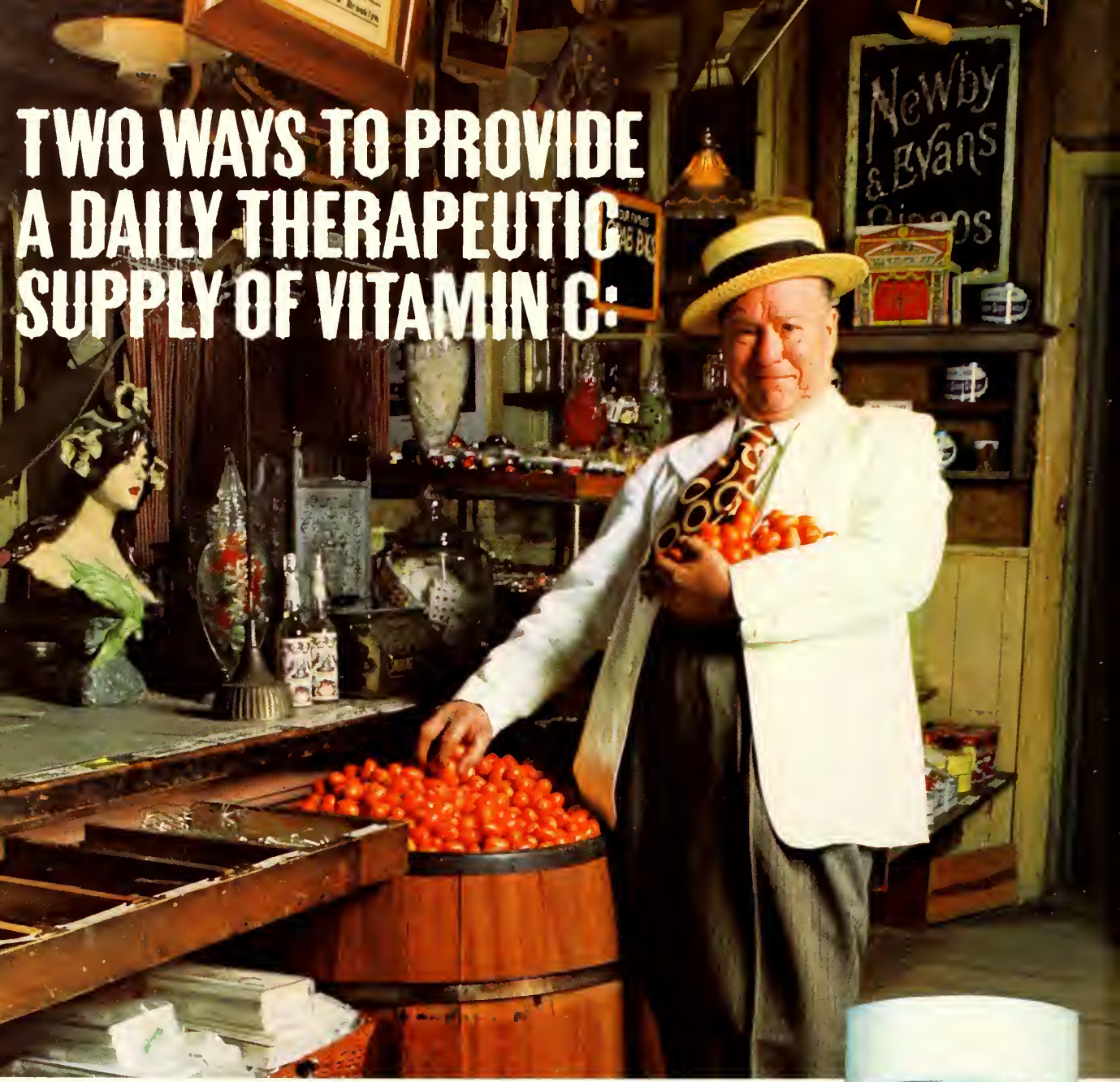
"the Donnatal® Effect"

	each tablet, capsule or 5 cc. of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
(Warning: may be habit forming)			

Brief Summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

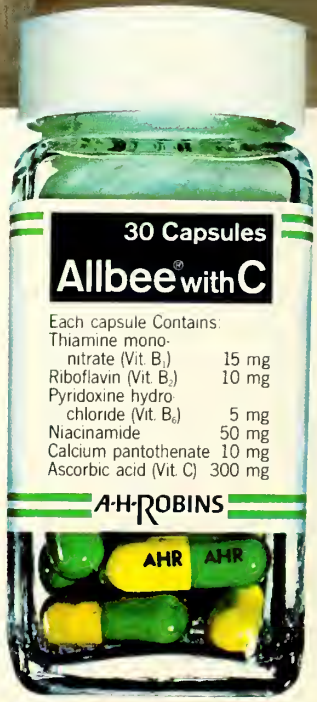
A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

A·H·ROBINS



TWO WAYS TO PROVIDE A DAILY THERAPEUTIC SUPPLY OF VITAMIN C:

50 KUMQUATS OR ONE ALLBEE® WITH C



Your patient would have to eat 1,500 kumquats a month, about 50 a day, to get as much Vitamin C as is contained in just one bottle of 30 Allbee with C capsules (taken one capsule daily). Allbee with C is a lot easier to come by too. Unlike kumquats, it's always in season. In addition, each capsule provides full therapeutic amounts of the B-complex vitamins. The handy bottle of 30 gives your patient a month's supply at a very reasonable price. Economy size of 100 also available. At pharmacies on your prescription or recommendation.

A. H. Robins Company, Richmond, Va. 23220

(Continued from Page 940)

tal depression, your doctor has indicated you need special supervision while taking oral contraceptives.

"Even if you don't have special problems, he will want to see you regularly to check your blood pressure, examine your breasts and make certain other tests."

An American Medical Association spokesman questioned the tone of the language of the FDA's draft of the leaflet.

"In general, it is a good idea to have a package insert but the text of the FDA proposal raises serious question about the relationship between doctor and patient," he said. "It puts the full responsibility on the physician, but oral contraceptives generally are prescribed more as a convenience to a patient than as a medication. The patient must share responsibility both morally and legally and be alerted to her own responsibility."

The FDA now requires that pharmaceutical manufacturers only warn physicians and pharmacists of side-effects and possible hazards of taking birth control pills. Makers of the drugs were given opportunity to comment on the proposed leaflet after its publication in the Federal Register.

* * *

Identical bills designed to increase the number of physicians and allied health personnel in family medicine have been introduced in the House and Senate. Sponsors of the legislation say that prospects are good for Congressional approval this year.

The legislation would authorize $50 million for the current fiscal year of 1971, $75 million for fiscal 1972 and $100 million for each of the next fiscal years for grants to medical schools and hospitals. The grants would be to help medical schools and hospitals establish departments and programs in family practice of medicine and to encourage the training of allied health personnel in that field of medicine.

Sen. Ralph W. Yarborough (D.-Tex.) sponsored the legislation (S. 3418) in the Senate. Thirty-one other senators, both Democrats and Republicans, were co-signers of the bill. Yarborough is chairman of both the Senate Labor and Public Welfare Committee and the Subcommittee on Health which will handle the legislation. An aide said the senator would schedule hearings and that he was confident the Senate would approve the legislation this year.

Rep. Fred B. Rooney (D.-Pa.) introduced the bill (H.R. 15793) in the House first this year. Rooney is a member of the House Interstate and Foreign Commerce Committee which will handle the legislation on that side of the capitol. Several other House members also introduced it separately.

Aides to both Yarborough and Rooney said they had worked with representatives of the American Academy of General Practice in drafting the legislation.

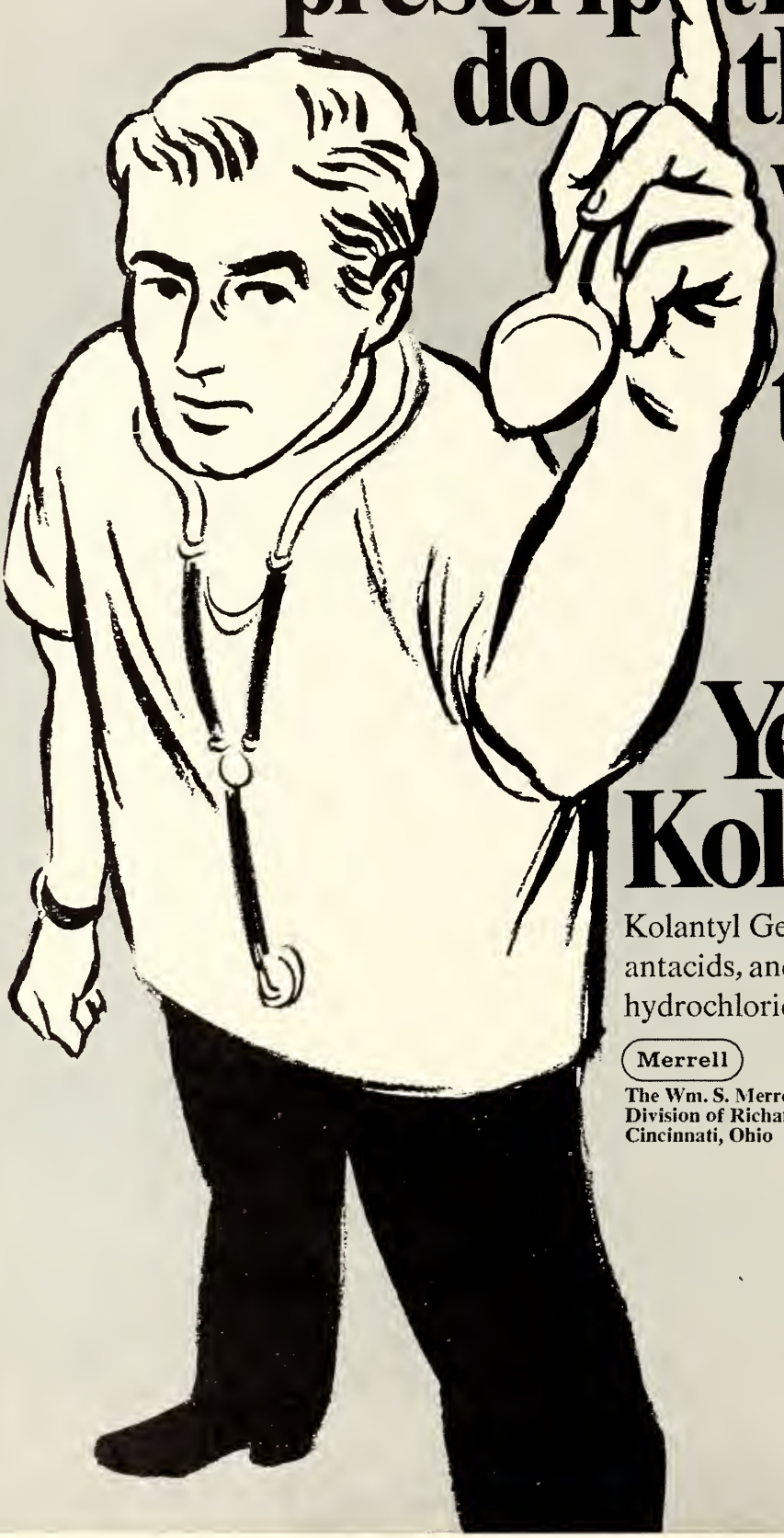
An Ethic Developed In Privacy

A Doctor of Divinity writes in the Medical Journal of Australia:

"If medical scientists and practitioners are to develop an ethic to match their new powers, it will be a sophisticated ethic, and it therefore must be developed in some privacy. By privacy I do not mean secrecy. It must be a discussion among those who are capable of understanding the issues at stake, and this may well include some from outside the profession. But it cannot immediately be translated into the language of the popular Press. It cannot, without risk of distortion, be equally understood by every patient, the sophisticated and the simple."

—Northwest Medicine.

Can one prescription do the work of two?



Yes, Kolantyl®.

Kolantyl Gel/Wafers contain antacids, and Bentyl® (dicyclomine hydrochloride) too.

Merrell

The Wm. S. Merrell Company
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215



Tubal Ligation And Abortion In The State Of Alabama

By Charles E. Flowers, Jr., M. D.

Birmingham, Alabama

The greatest danger to this country is probably not from a communistic invasion from a totalitarian nation. We probably should be more concerned about a "cancer" which is growing within this country; this comparison is not made lightly. If we think of cancer as a growth of cells which contribute nothing to body functions, but eventually destroy the vital organs because their proliferation prevents adequate nutrition to the vital organs, one may say that the cancer that is endangering the vital economy of this country is the proliferation of a large group of people who contribute little to our gross national product but are threatening the vital organs of our country. These are a vibrant industry, a free enterprise system, and a motivated populace. If we feel that overpopulation threatens us from within because of pollution and reduced ability to provide health and education services, we must develop programs which will control this population.

Obviously we would like to do this with a voluntary system of control which is based primarily upon a system of family planning. In the book entitled, "The Poor Shall Bear Children," it was stated that 40 percent of births which occur in this country were unplanned and unwanted. A similar study was made at the University of North Carolina and at the University Hospital in Birmingham, Alabama, which indicated that 80 percent of the pregnancies among lower social groups were unplanned and unwanted. In North Carolina, where there was also a group of private patients, it was found that the incidence of unplanned, unwanted pregnancies among this group was only 15 percent. This means that the largest number of people who are having unplanned children are lower social groups whose family plan-

Department of Obstetrics and Gynecology, University of Alabama.

This presentation was made at a meeting of the Alabama Advisory Council, October 30, 1969.

ning methods are inadequate. There is considerable evidence to indicate this, since the incidence of illegitimate pregnancies is increasing among both teen-agers and older women.

What effects are these unplanned, unwanted, and teen-age pregnancies having upon the health of the community? They are associated with medical and obstetric complications of the mothers, and a high incidence of prematurity, mental retardation, and cerebral palsy among the infants. Prematurity is the greatest problem in both obstetrics and pediatrics. The highest incidence of prematurity is among lower social groups and mothers with obstetric complications; thus, there is a vicious cycle which must be broken. We are also seeing increased numbers of battered children and low birth weight infants. Both of these groups of children are all too frequently born into homes with very poor facilities, minimal incomes, and an inadequate mother or father image to assist the child in making a reasonable social adjustment. Thus, the child does not develop normal motivation and, therefore, fails to reach the potential that it might be able to achieve with the genetic material available.

There is a sizeable cost to society for the maintenance of these unplanned and unwanted children. Each illegitimate child, or child that does not have a proper home or parents to provide support, costs about $1,000 per year per child until the age of 17. In estimating this $1,000 per year per child, one takes into consideration food, clothing, housing, medical care, hospital care, education, police protection and recreation facilities. One thousand such children are being born in only one year in Birmingham. If one will extrapolate these figures for the State of Alabama for a ten-year period, the millions of dollars that are involved will be apparent. It has also been estimated that for each mentally retarded or cerebral palsied infant the cost for the care of the child during its entire life to the age 65 is in excess of $150,000. The incidence of prematurity, cerebral palsy and mental retardation in infants for which the support depends primarily upon the state, is highest among lower social groups and among unwanted, unplanned pregnancies.

The rapid increase in the number of citizens who cannot adequately provide for themselves is also responsible for the deterioration of our school systems, the increase in major crimes, the inadequate and expensive cost of outpatient and hospital care to the indigent, enormous increase in Aid to Dependent Children, the cost of MEDICAID, and the clamor for a guaranteed income of $5,800 for a family of four.

We do not like merely to discuss the monetary aspects of health care, but money is money, and there is far too little of it in the State of Alabama. But I am sure that the people in this state are equally concerned about health.

It has long been known that people who have limited education and limited resources do not practice preventive medicine and, when illnesses occur, they are generally always more severe than similar illnesses which occur within the healthy portion of the population. It is also true that the largest amount of trauma tends to occur among unemployed and lower social group patients. Thus, the health needs of our state and community which are already inadequate, will probably become more so within the next decade.

This group of people also places a strain upon our educational system. It is extremely important that a quality type of educational program be developed. This is particularly true since the need for uneducated individuals in the working force of our nation is being rapidly reduced each year. It, therefore, becomes important to increase the amount of education available in order that individuals will be prepared for the jobs which are developing in a space age economy. When the state must spend tremendous amounts of money merely keeping people

alive and providing the necessities of life, there are often insufficient funds available for education and nutrition. There is little doubt that under and malnutrition are becoming a major problem that will be of equal importance as pollution. Pollution is a function of an overpopulated society, while nutrition can only be corrected when there is the equalization of births to the natural resources which are available.

There is developing evidence today to indicate that if a child receives poor nutrition while it is in the uterus, and inadequate food and nutrition during the first year of life, mental retardation may develop simply because inadequate nutrients were available during the rapid growth phase of the central nervous system. It is, thus, apparent that the vicious circle becomes tighter and tighter, and can only be broken if additional methods of family planning are found and utilized with the presently available methods of population control.

If we will admit that these problems exist, it is certainly apparent that solutions must be sought. It is extremely important that each community in Alabama study its population problem, as well as the problems of delivering health care and education. With each community understanding its own problems, solutions to the state's problems will be more easily solved.

Dr. Joseph Beasley, in New Orleans, did a very important study which indicated the tremendous success which could be achieved when a community studied its population and welfare problems and sought solutions. New Orleans represents a blighted inner city with massive unemployment, a tremendous birth rate, as well as inadequate educational and health facilities.

Dr. Beasley and his group mounted a plan to attempt to detrmine methods by which the number of unplanned, unwanted pregnancies could be reduced. He was able to achieve, in the parish of New Orleans, a 33 percent reduction in indigent births and a 40 percent reduction in illegitimate births when a coordinated system of family planning was initiated. However, in a control parish, Lincoln, a few miles west of New Orleans, there was a 13 percent rise in illegitimate births when no attempts were made to solve the population problems within the community. Dr. Beasley found that there were methods by which lower social groups and unemployed could be reached and motivated to use family planning, and at the same time become more conscious of the health problems of themselves and their children.

The University of Alabama Medical Center is attempting to help solve some of the problems of our state in a number of ways.

The University of Alabama proposes to develop a Population Center which will study population in its broadest sense, in order that solutions to the problems which have been enumerated may be found. Alabama has a unique opportunity to develop an outstanding center, since we have great social, financial, and health problems among our white and black citizens, and in rural and urban areas. There will be Divisions of Sociology, Epidemiology and Public Health, Demography, Education, Religion, Nutrition, Urban Affairs, as well as various bio-medical units in the center.

We have also developed a liberalized policy of sterilization within the medical center. Tubal ligation is available to:

1. Any person below the age of 30 with 3 children
2. Any person above the age of 30 with 2 children
3. Any patient who is 21 years of age or older and has 2 or more illegitimate children

What we need desperately, however, is a law which will allow sterilization without a husband's consent if there have been *two or more years of separation or abandon-*

(Continued on Page 949)



Not just the tough cases...

Depend on Candeptin® (candicidin) as the agent of first choice in all Candida cases.










Symptoms subside in 48 to 72 hours!
Itching, burning, discharge, and malodor disappear rapidly... patient's embarrassment, too.

Avoids the disappointment of "the cure that didn't take."
CANDEPTIN is "cidal" as well as "static," it is 100 times more potent *in vitro* than nystatin,[2] and it has achieved culture-confirmed cure rates of 90% and more[3] (even in notoriously difficult-to-treat pregnant patients).[1,3,4]

And two weeks does it.
Usually, CANDEPTIN cures in a single 14-day course of therapy.[3]

the fortnight fungicide
Candeptin®
candicidin
Vaginal Tablets/Ointment

Formula: CANDEPTIN Vaginal Ointment contains a dispersion of candicidin powder equivalent to 0.6 mg. per gm. or 0.06% candicidin activity in U.S.P. petrolatum. 3 mg. of candicidin is contained in 5 gm. of ointment or one applicatorful. CANDEPTIN Vaginal Tablets contain candicidin powder equivalent to 3 mg. (0.3%) candicidin activity dispersed in starch, lactose and magnesium stearate.

Indications: Vaginal moniliasis due to *Candida albicans* and other Candida species.

Contraindications: Patient sensitivity to any of the components. During pregnancy manual tablet insertion may be preferred since the use of the ointment applicator or tablet inserter may be contraindicated.

Caution: Clinical reports of sensitization or temporary irritation with CANDEPTIN Vaginal Ointment or Vaginal Tablets have been extremely rare. To avoid reinfection, it is recommended that the patient refrain from sexual intercourse during treatment or the husband wear a condom.

Dosage: One vaginal applicatorful of CANDEPTIN Ointment or one Vaginal Tablet is inserted high in the vagina, twice a day, in the morning and at bedtime, for 14 days. Treatment may be repeated if symptoms persist or reappear.

Dosage forms: CANDEPTIN Vaginal Ointment is supplied in 75 gm. tubes with applicator (14-day regimen requires 2 tubes). CANDEPTIN Vaginal Tablets are packaged in boxes of 28, in foil, with inserter—enough for a full course of treatment. Store under refrigeration.

Federal law prohibits dispensing without prescription. CANDEPTIN is a registered trade-mark of Julius Schmid, Inc.

References: 1. Olsen, J. R.: Journal-Lancet *85* 287 (July) 1965. 2. Lechevalier, H. Antibiotics Annual 1959-1960, New York, Antibiotica, Inc., 1960, pp. 614-618. 3. Giorlando, S. W., Torres, J. F., and Muscillo, G. Am. J. Obst. & Gynec. *90* 370 (Oct. 1) 1964. 4. Friedel, H. J.: Maryland M. J. *15* 36 (Feb.) 1966.

Julius Schmid Pharmaceuticals
423 West 55th Street
New York, N.Y. 10019

(Continued from Page 947)

ment. We have many multiparous patients who have had a number of children by several men, who cannot be sterilized because we do not have the husband's consent, despite the fact the woman has not lived with her husband or even known his whereabouts for a number of years. We may be subject for law suits for mayhem for this practice of tubal ligation. *Thus, legislation clarifying the sterilization laws in Alabama is required.*

We are also attempting to interpret the abortion law of Alabama in a more liberal manner. The Alabama law states that an abortion may be performed to preserve the life or health of the mother. We would like to interpret *health* in the same way as it is interpreted by the American College of Obstetricians and Gynecologists and the American Medical Association.

These bodies of organized medicine have recommended that the health of an individual be broadly interpreted in regard to the present, as well as the future, sociologic and economic condition of the patient. This would allow an abortion to be performed on adolescents and older women, when the family is too large to assure its members of reasonable living conditions and economic support, or, when psychiatric conditions affect health, even in nonsuicidal conditions. With a liberal interpretation of the law, an abortion may be done for rape and incest, and when it is believed that the child will be born with major congenital abnormalities since the conditions will certainly affect the sociologic and economic conditions of the mother.

The medical school faculty is now broadly interpreting the present Alabama abortion law covering health as an academic endeavor to determine the medical effects of this interpretation.

Thus, we feel we cannot offer these liberalized abortions to residents other than in Jefferson County. However, we strongly urge other communities in the state to re-

view their own policies of tubal ligation and abortion and provide them equally to indigent as well as private patients.

We hope that *our legislature will clarify and liberalize our abortion laws.*

I am greatly concerned about the problems of overpopulation in the world; it is not solvable in many countries. Mass starvation and epidemics are unavoidable. It can be solved in this country and in Alabama. Not to do so will prevent this state from reaching its great potential. Not to do so will certainly ultimately lead to punitive legislation and a reverse income tax in relation to family size, but above all, a reduction in the individual rights of everyone.

These things are, to me, unacceptable. Let us have planned and wanted children according to the principles of freedom of choice, freedom of understanding, and freedom of dissent.

Physicians Wanted to be part of a group to provide full-time coverage in the

EMERGENCY ROOM

at

DRUID CITY HOSPITAL

40 hour week - vacation - Earnings in proportion to collections, with minimum guaranteed - - - Enjoy good hours in a University town. Active emergency service - - yet release of responsibility when not at work. Write or call collect:

D. O. McCLUSKY, JR.,
Administrator
Druid City Hospital
Tuscaloosa, Alabama 35401
205-752-7441

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA
Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY
Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: MRS. ELIZABETH HARKINS, ACSW, *Coordinator of Admissions*

or

SAMUEL N. WORKMAN, M. D.
Chief of Clinical Services

CHARLES W. NEVILLE, JR., M. D.
Assistant Professor of Psychiatry and Medical Director

Area Code 704 - 254-3201



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps



Treating atrophic vaginitis complicated by infection... **is as easy as AVC/Dienestrol**

Dienestrol helps restore estrogen-deficient vaginal mucosa. It is the *particular* ingredient in AVC/Dienestrol that improves cell maturation counts[1,2] — helps stimulate the restoration of normal vaginal epithelium to resist infection.

Two recent studies reconfirm AVC/Dienestrol efficacy.[1,2] AVC/Dienestrol is proven effective against monilial, trichomonal, nonspecific bacterial vaginitis, and mixed infections.[1,2] AVC/Dienestrol combats infection, helps restore tissue resistance to reinfection.

So even in complex cases, the treatment can remain the same. Comprehensive. Effective. Easy as AVC/D.

Cantraindications: Known sensitivity to sulfanamides; diagnosis or familial history of carcinama of the genital tract or breasts; precarcinamatous lesions of the vagina or vulva; palpable uterine fibramyama; mammary fibroadenama; depressed liver function.

Precautians/Adverse Reactians: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity or sensitivity are reasons to discontinue treatment. The use of AVC/Dienestrol does not preclude the necessity for careful diagnostic measures to eliminate the possibility of neoplasia of the vulva or vagina. Manifestations of excessive estrogenic stimulation through dienestrol absorption may occur. These include uterine bleeding, breast tenderness, exacerbation of menstrual irregularity and provocation of serious bleeding in women sterilized because of endometriosis. Endometrial withdrawal bleeding may occur if use is suddenly discontinued.

Dosage: One applicatorful or one suppository intravaginally once or twice daily.

Supplied: 'AVC/Dienestrol Cream'—Four ounce tube *with* applicator. 'AVC' and 'AVC/Dienestrol Suppositories'—Box of 12 *with* applicator.

References: (1) Solerna, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. (2) Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

AVC/Dienestrol

Cream (dienestrol .01%, sulfanilamide 15.0%, aminacrine hydrochloride 0.2%, allantain 2.0%)
Suppositories (dienestrol 0.70 mg., sulfanilamide 1.05 Gm., aminacrine hydrochloride 0.014 Gm., allantain 0.14 Gm.)

TRADEMARK A V C AV-920A 7/69

Fathers and Sons in Medicine

7 Stablers Have Practiced Or Will Practice In Greenville

Speaking of fathers-and-sons-in-medicine and, at the same time, of the critical shortage of physicians, where would Greenville be without the Stablers?



Dr. L. V. Stabler

It all began with the late Lorenzo Vastine Stabler, M.D., born in Braggs, Dallas County, April 22, 1875, the son of Ella Belle (McFerrin) and Andrew Vandy Vastine Stabler. He received his medical education at the University of Alabama and Vanderbilt, 1895-98, and after three years' practice in Ackerville, moved to Thorsby, where seven years' residence established him as a leading citizen and president of the Thorsby Bank. His next and final move was to Greenville in 1910, where his importance to that community is best attested by his election as Man-of-the-Year in 1951 by the Chamber of Commerce.

He is the first of seven Drs. Stabler to have an impact or a prospective impact on Greenville and Butler County, and when it is remembered that the total membership of the Butler County Medical Society is ten, the importance of that impact is recognizable.

Dr. L. V. Stabler's younger brother, Andrew Lee Stabler, M.D. left his practice in Birmingham in 1915 to move to Greenville, where the two brothers built the Stabler Infirmary. Eight years later, after taking graduate work in Buffalo, N. Y., the latter Dr. Stabler returned to Birmingham where he would remain in practice for the rest of his life, specializing in nutritional diseases and surgery.

Today, two of Dr. L. V. Stabler's sons and two grandsons are leading physicians and surgeons in Greenville, while a third grandson, who interrupted his education for service as an officer in his country's navy, is working toward his M.D. degree in the University of Alabama Medical School.

Ernest Vernon Stabler, Sr., presently the elder statesman of Greenville's practicing Stablers, was born in Thorsby on June 24, 1904, receiving his baccalaureate degree from the University of Alabama, his M.D. from Harvard, his residency both in surgery and gynecology at Roosevelt Hospital, New York City. He played basketball in his undergraduate days at Alabama, where he led the Southeast Conference in scoring. His present hobbies are hunting and fishing and he has a place on the Gulf coast, at Seagrove. Married to the former Annie Hunter Acker of Mobile, Dr. Stabler's two sons (there are also two daughters) practice medicine in Greenville.

His brother, Aubrey Ayer Stabler, M.D., was born in Thorsby on Valentine's Day, Feb. 14, 1909. After receiving both B.A. and B.S. degrees from the University of Alabama, he earned his M.D. from the Medical College of South Carolina. He was just completing his graduate work on his specialty, Urology, although associated with the Stabler Clinic since 1940, when Pearl Harbor went up in flames, and he entered the Air Force, separating from service in 1946 with the rank of major.

Dr. A. A. Stabler is married to the former Louise Kuhland of Charleston, S.C. They have a daughter and a son, A. A., Jr., who is presently working on his M.D. degree.

Dr. Aubrey Ayer Stabler was 1969 vice president of the Butler County Medical Society, scheduled to step into the presidency at the 1970 election meeting. And his eldest nephew, Paul Acker Stabler, M.D., was secretary-treasurer of the Butler County Society and a member of its Board of Censors.

This nephew, the son of Ernest Vernon Stabler, M.D., was born in Greenville June 5, 1933, received his baccalaureate and M.D. degrees from the University of Alabama, sandwiching between them a two-year tour of duty with the Army. Interning and then completing a three-year residency in internal medicine at the University of Alabama Medical Center, he returned to Greenville and to active practice in July, 1966. He is married to the former Anne Gardner Crume and there are three children: Vivian, 6; Elizabeth, 5; and Paul, Jr., 1 year old.

Ernest Vernon Stabler, Jr., M.D., who rounds out the quartet of Stablers presently practicing medicine in Greenville, followed his older brother a year later, began his practice of surgery in the Stabler Clinic in 1967. Also born in Greenville, graduating from Greenville High School and with his baccalaureate from the University of Alabama, this Dr. Stabler earned his M.D. from Johns Hopkins, and served his internship and surgical residency at Roosevelt Hospital, New York. His two years of military service included a year at Martin Army Hospital, Fort Benning, Ga., and a year in Vietnam.

Dr. Ernest Vernon Stabler, Jr., is married to the former Margaret Partlow Pritchett and they have three children: Vernon III, Hunter and Kathleen.

And finally, for now, there is Aubrey Ayer Stabler, Jr., born July 5, 1941, in Greenville, completing his high school education there before attending Vanderbilt University, from which he obtained his B.A. degree in Chemistry in 1964. Entering the Naval Officer Candidate School, he was commissioned an ensign, and served three years aboard the USS Page County 1st-1076, with San Diego, Calif., as his home port.



A 2nd AND 3rd GENERATION of Greenville MD's:—Seated, Drs. A. A. Stabler, Sr., and E. V. Stabler, Sr., with their sons posed behind them: A. A., Jr., behind his father; Vernon, Jr., and Paul Acker Stabler behind theirs.

Following his tour of duty, he took two years of post-graduate work at the University of Alabama before entering the University's Medical School last September, serving as Freshman Class Representative. He was married to the former Brenda Leigh Stanford of Montgomery Aug. 24, 1968.

This youngest of the present third generation of Stablers destined to enter the Medical profession, broke precedent when he entered the Sigma Chi social fraternity, just as his two cousins broke precedent before him when they became Kappa Alphas. Their father and their uncle had been PiKA's.

There is still another Stabler doctor in the family. He is Almon Clark Stabler, who spent two years at the University of Alabama before going on to the Pennsylvania Medical School for his M.D. degree, and has made that state his home since then. Dr. Almon Stabler is now in general practice in Ambler, Penn.

Today's senior Stablers have two other brothers: Carey V. Stabler, Ph.D., chancellor of the Little Rock division of the University of Arkansas, and Vastine, eldest of the brothers, who operates a paint factory in Birmingham.

(Continued on Page 956)

EIGHTY-FIRST ANNUAL MEETING

of the

MID-SOUTH MEDICAL ASSOCIATION

(Formerly Mid-South Postgraduate Medical Assembly)

MAY 27, 28, 29, 1970

at the

HOLIDAY INN-RIVERMONT MEMPHIS, TENNESSEE

Outstanding speakers will present half-hour lectures on subjects of interest to both general practitioner and specialist. A well balanced program is scheduled. Make your plans to attend NOW!!

CLASS REUNIONS: Class of 1930; Class of 1935—March, June, September, December; Class of 1939—December; Class of 1940—March, June, September, December; Class of 1945—March, June, September, December; Class of 1950—March, June, September, December; Class of 1955—March, June, September; Class of 1956—June; Class of 1960—March, June, September, December; Class of 1965—March, June, September, December.

MAKE YOUR PLANS NOW TO ATTEND THE

MID-SOUTH MEDICAL ASSOCIATION

MAY 27, 28, 29, 1970

MEMPHIS TENNESSEE

Two Of Jordan Medical Trio In Birmingham, One In Atlanta

There is no rule for the pronunciation of proper names. You may spell yours J-o-n-e-s and pronounce it Smith, if you wish.

So, it will be remembered that an Alabama family named Jordan (pronounced Jowrdan) was the subject of a father-and-son feature three months ago. And today an Alabama family named Jordan (pronounced Jerrdan) is the current subject.

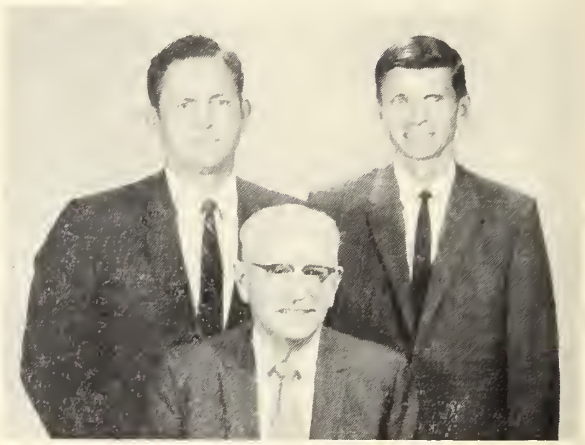
This trio of Jordans is headed by John Sheffield Jordan, Sr., M.D., born in Union Grove, Ala., July 2, 1888.

After a preliminary education in the schools of Marshall County and in the 7th District Agricultural School, he taught school and served in his country's military before entering Auburn in 1919, transferring from there to Emory the next year from which he was graduated with an M.D. degree in 1925. He interned at St. Joseph Infirmary, Atlanta, followed with a residency at Woodlawn Hospital, Birmingham, and in the outpatient clinical service at Hillman.

He served from 1917 to 1919 in World War I, and from 1942 to 1945 in World War II, wearing the oak leaves of major when he returned to civilian life. He served as Chief of OB-Gyn at East End Memorial Hospital 1949-1968, and is at present Chief of OB Emeritus. He became semi-retired last July 1st.

Mrs. Jordan is the former Orma Montgomery of Fayetteville, Tenn., and there are four children: Mrs. Bettye Trucks, Auburn; Mrs. Jane Thompson, Atlanta; John Sheffield Jordan, Jr., M.D., Birmingham; and William Daniel Jordan, M.D., Atlanta. A member of the Woodlawn Baptist Church, the senior Dr. Jordan's hobbies are reading and a small woodwork hobby shop.

John S., Jr., was born in Birmingham Sept. 14, 1928, finished Woodlawn High, and received both his baccalaureate and M.D. degrees from Emory. He interned and served his residence at Grady Memorial Hospital, Atlanta. He is a Diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons.



DANIEL, SR. & JR.
(In That Order)

This Dr. Jordan is married to the former Mary Rogers of Blakely, Ga., and they have two children: Mary Martha Jordan, born April 3, 1954; and John Sheffield Jordan III, born March 13, 1956. A Deacon in the Woodlawn Baptist Church, a past president of the Southside Boys Baseball Club, president of the Woodlawn Colonels Club, a member of the Cumberland Lake Country Club, and of the Mountain Brook Swim and Tennis Club, an Army Captain (1956-58), listing his hobbies as golf and tennis, his social fraternity is Sigma Alpha Epsilon, his medical fraternity Phi Chi, and his honorary Phi Sigma.

W. Daniel Jordan, M.D., was born Oct. 29, 1934, received both his baccalaureate and M.D. degrees from Emory, interned and had his residency in straight surgery and general surgery at Grady, Atlanta, served his tour of Air Force duty at Mountain Home AFB, Idaho.

Mrs. Daniel Jordan is the former Margaret Linch, and they have six children ranging in age from 13 to 6:—Albert Linch, Dana,

(Continued on Page 958)



Blue Shield's new URC program recognizes your "out-of-the-ordinary" charges through individual consideration by review committees composed of physicians.

BLUE CROSS-BLUE SHIELD OF ALABAMA

®

(Continued from Page 956)

Margaret Noel, Amanda Bonanna, Grey, and Will. This Dr. Jordan is a member of the St. James Anglican Church, Atlanta, and he lists his hobbies as golf, skiing, and tennis, in that order.

He is presently in the Department of Surgery, on the active staffs of St. Joseph's Infirmary and Doctors Memorial Hospital, on the Courtesy Staffs of DeKalb General Hospital and Crawford W. Long Hospital.

Lead Poisoning Still Exists

. . . The danger of lead poisoning from paint is not a thing of the past in spite of the fact that the use of lead pigments in interior house paints has been discontinued for more than 20 years.

The woodwork and walls of many old apartments and houses may still be covered by many layers of lead-based paints. As a result small children (between the ages of one and five) living in these old dilapidated quarters may gnaw on peeling window sills and eat the flakes of paint that come off the walls . . .

. . . Lead poisoning is often not recognized because of the similarity of the symptoms to many other childhood difficulties such as anemia, convulsions, fits simulating epilepsy, stomach ache, nausea and mental retardation. The diagnosis of lead poisoning can be confirmed by urinalysis and blood analysis . . .

The contamination of the air by lead-containing gasoline is being studied and the toxic effects of such polluted air are far from minimal.

—Journal of the American Medical Women's Association.

A Prophet—Not Without Honor

Almost unnoticed in a world preoccupied with physical, mental, emotional and spiritual health, the doctor who first announced that cancer can be caused by a virus nearly 60 years ago, died at the age of 90.

His announcement, greeted with derision almost everywhere at the time, and from which he turned subsequently to studies of the blood, brought him a belated Nobel prize in medicine just four years ago.

He is Francis Peyton Rous, M.D., born in 1879. He announced his finding in 1911 after a farmer had brought him a chicken with a highly malignant cancer, which he ground, filtered, and injected the cell-free extract into healthy chickens, finding that some developed sarcoma.

Not just a motel it's a Guest House

. . . with 171 handsome rooms designed for your comfort and convenience. A center-of-everything location including Birmingham's University of Alabama Medical Center . . . making The Guest House a favorite of Doctor's wives and in-town outpatients. Superb dining, dancing and nightly entertainment. Come stay with us often.

THE RESTAURANT
THE PLAYROOM • CYPRESS ROOM
CONVENTION FACILITIES



The Guest House
MOTOR INN

PHONE 324-8653
16TH ST. &
10TH AVE., SOUTH
BIRMINGHAM, ALABAMA

"Where the Action Is!"



around the state

Vital Statistics

NEW MEMBERS

Clarke County

Neal, Ralph Dewey, Jr., b 38, mc Alabama 64, sb 65, Grove Hill, Alabama 36451 I

Houston County

Hilbert, John Frederick, b 35, mc Emory 60, recip. Georgia 69, 409 W. Main Street, Dothan, Alabama 36301 S

Lee County

Claybrook, James Lynn, b 32, mc Alabama 57, sb 58, Medical Arts Center, Opelika, Alabama 36801 Ob G

Druhan, Frank David, b 36, mc Alabama 62, sb 63, Medical Arts Center, Opelika, Alabama 36801 Pd

Mardre, Robert Burton, Jr., b 32, mc Alabama 60, sb 61, 1706 Hill Top Circle, Opelika, Alabama 36801

Montgomery, Guy Austin, Jr., b 38, mc Alabama 62, sb 63, Medical Arts Center, Opelika, Alabama 36801 U

Thoroughman, James Chanslor, b 04, mc Emory 27, recip. Georgia 69, Medical Arts Center, Opelika, Alabama 36801 S

Veach, Everett Gaines, b 37, mc Emory 62, recip. Georgia 69, Medical Arts Center, Opelika, Alabama 36801 Or

Webb, William Allen, b 36, mc Emory 62, recip. Georgia 69, Medical Arts Center, Opelika, Alabama 36801 S

Walker County

Russell, Bruce Wayne, b 42, mc Alabama 67, recip. NBME 68, Carbon Hill, Alabama 35549

DEATHS

Walker County

Brown, James L., Carbon Hill, Alabama 35549 ..... Deceased

Taggart, John K., 313 18th St., Jasper, Alabama 35501 ..... Deceased 2/6/70

CHANGE OF ADDRESS

Clarke County

Elmore, Gary Sylvester, present Grove Hill to Bridgeport, Alabama 35740

Dallas County

Alison, James F., present Selma to P. O. Box 327, 509 Parkman Avenue, Selma, Alabama 36701

DeKalb County

Walker, James A., present Fort Payne to 1214 Forrest Avenue, North, Fort Payne, Alabama 35967

Jefferson County

Blankenship, Brantle E., present Birmingham to 1620 14th Avenue, So., Birmingham, Alabama 35205

Cezayirli, Cemil, present Birmingham to 3015 7th Avenue, So., Birmingham, Alabama 35233

Compton, Merrill E., Jr., present Birmingham to 406 Professional Bldg., 801 Princeton Avenue, Birmingham, Alabama 35211

Davie, James C., present Birmingham to 514 Medical Arts Building, Birmingham, Alabama 35205

Doss, Faye W., present Birmingham to Pro-

fessional Bldg., 801 Princeton Avenue, Birmingham, Alabama 35211

Henderson, Ronald E., present Birmingham to 4301 Kennesaw Drive, Birmingham, Alabama 35213

Hughes, Brady A., present Birmingham to 1211 Spring Street, Tarrant, Birmingham, Alabama 35217

Miller, James A., present Birmingham to 2037 Fayette Avenue, Birmingham, Alabama 35208

Osband, Richard, present Birmingham to 2016 10th Avenue, South, Birmingham, Alabama 35205

Pitts, Edward B., present Birmingham to Professional Building, 801 Princeton Avenue, Birmingham, Alabama 35211

Reque, Paul G., present Birmingham to 800 Montclair Rd., Birmingham, Alabama 35213

Ross, John W., present Birmingham to Professional Building, 801 Princeton Avenue, Birmingham, Alabama 35213

Roy, Barbara Jean, present Fairfield to 800 Montclair Road, Birmingham, Alabama 35213

Tucker, Mylan S., present Birmingham to 700 Memorial Drive, Bessemer, Alabama 35020

Ward, John L., present Birmingham to 1025 South 18th Street, Birmingham, Alabama 35205

Watson, Horace E., present Birmingham to 406 Professional Building, 801 Princeton Avenue, Birmingham, Alabama 35211

Lauderdale County

Dunn, Milton C., present Florence to 615 Riverview Drive, Florence, Alabama 35630

Macon County

Williams, Joshua W., present Tuskegee Institute to Drawer II, Tuskegee Institute, Alabama 36081

Mobile County

Brown, Nelson L., present Mobile to P. O. Box 4158, 1406 Dauphin St., Mobile, Alabama 36604

Jones, Frederick B., present Mobile to P. O. Box 7525, 1557 Springhill Avenue, Mobile, Alabama 36604

Mitchell, George J., present Mobile to P. O. Box 7525, 1557 Springhill Avenue, Mobile, Alabama 36604

Stamm, James Edward, present Mobile to P. O. Box 7525, 1557 Springhill Avenue, Mobile, Alabama 36604

Traveis, Leonard F., present Mobile to P. O. Box 7525, 1557 Springhill Avenue, Mobile, Alabama 36604

Tunstall, Peyton R. Jr., present Mobile to P. O. Box 4158, 1406 Dauphin Street, Mobile, Alabama 36604

TRANSFERS

Houston County

Clark, Glenn Luther, 509 W. Main St., Dothan, Alabama 36301 (ALR) from member Talladega County Medical Society to member Houston County.

Brice, Donald W., 1604 Choctaw St., Dothan, Alabama 36301 (ALR) from member Jefferson County Medical Society to member Houston County.

Walker County

Noguera, John F., Route 2, Box 57-B, Quinton, Alabama 35130 (GP) from member Jefferson County Medical Society to member Walker County.

CHANGE OF SPECIALTIES

DeKalb County

Walker, James A., 1214 Forrest Avenue, North, Fort Payne, Alabama 35967—Surgery

(Continued on Page 964)



f you can hang on for a few more minutes, Doctor, 'm sure I'll sneeze again."

d sneeze. And sneeze some more. But with Novahis- e LP, most patients get prompt and long-lasting ie from the symptoms of allergies and colds. These n nuous-release tablets have a vasoconstrictor-anti- st nine formulation that begins working in minutes, er continues to provide relief for hours. Even when s congestion is due to repeated allergic episodes, o Novahistine LP tablets, morning and evening, let most patients breathe freely all day and all night. Use with caution in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Novahistine® LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

DOW THE DOW CHEMICAL COMPANY Rx Pharmaceuticals Indianapolis



Owner Breaks Arm When Yacht Runs Aground

Schuyler, Oct. 31. Harry Waters of Covesville incurred a fractured arm [illegible] large rock tially capsized. The fire departn had to rescue Waters by small b Damage to the yacht is estimate

Hasn't the skipper had enough excitement for one day?

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

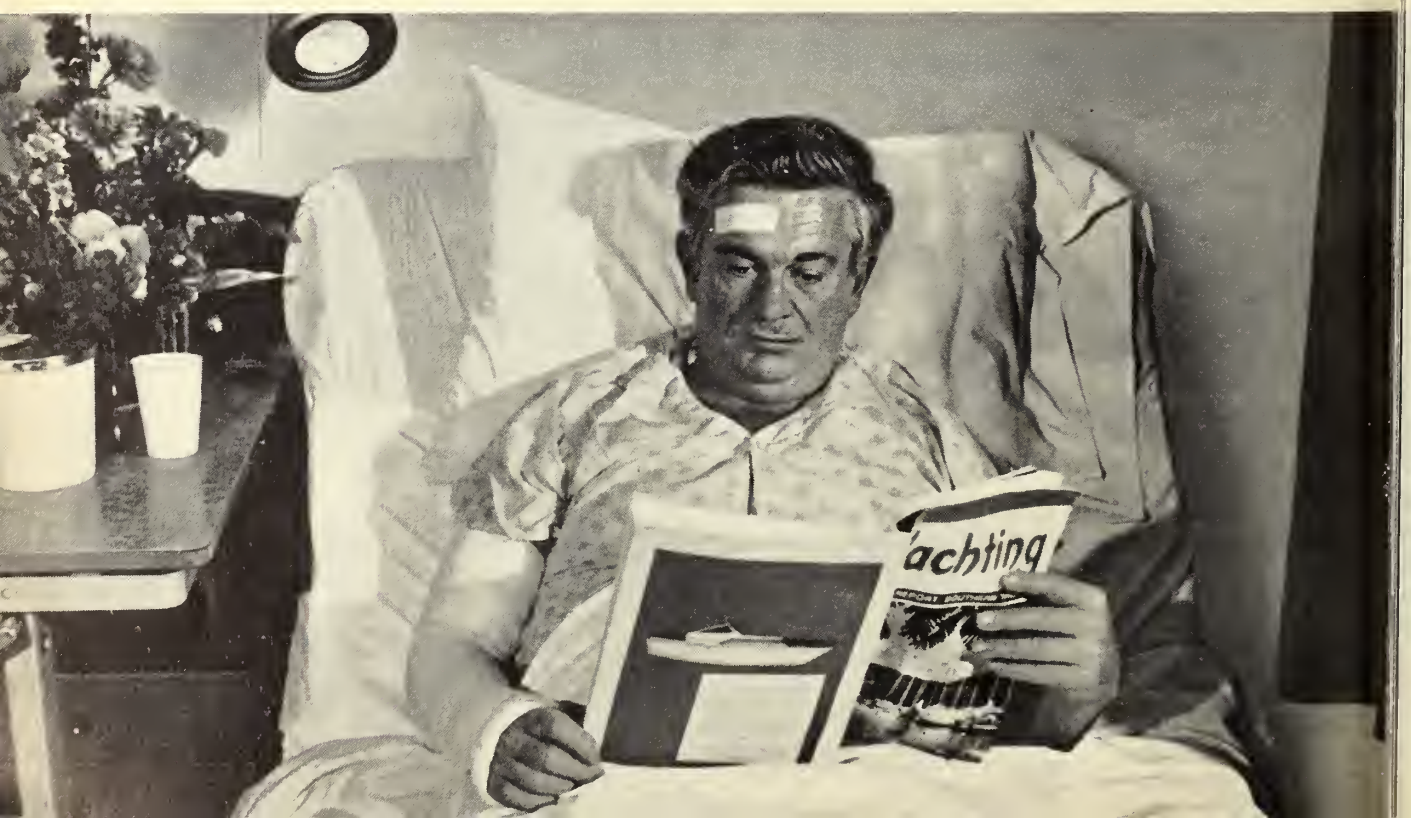
A.H. Robins Company, Richmond, Va. 23220 A·H·ROBINS

Phenaphen® with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.



for the problem drinker



Berocca®

TABLETS
high potency B-complex and C
for nutritional support

AVAILABLE ONLY ON Rx

contains water-soluble vitamins only

b.i.d. dosage

good patient acceptance

no odor, and virtually no aftertaste

Each Berocca Tablet contains:

Thiamine mononitrate	15 mg
Riboflavin	15 mg
Pyridoxine HCl	5 mg
Niacinamide	100 mg
Calcium pantothenate	20 mg
Cyanocobalamin	5 mcg
Folic acid	0.5 mg
Ascorbic acid	500 mg

Usual dosage is one tablet b.i.d.

Indications: Nutritional supplementation in conditions in which water-soluble vitamins are required prophylactically or therapeutically.

Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B_{12}.

Dosage: 1 or 2 tablets daily, as indicated by clinical need.

Available: In bottles of 100.

ROCHE

Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

(Continued from Page 960)

Etowah County

Skelton, Bennie L., 1011 Forrest Avenue, Gadsden, Alabama 35901—Pediatrics

Madison County

Elwell, Hildreth B., Jr., NASA Medical Center, A&TS MS M Marshall Space Flight Center, Alabama 35812—Industrial Practice

NEW TELEPHONE NUMBERS

Canup, Clarence N., Calhoun	237-7577
Claybrook, James L., Lee	745-6447
Doss, Faye W., Jefferson	785-3145
Druhan, Frank D., Lee	749-8121
Harlin, Robert S., Mobile	432-1879
Hilbert, John F., Houston	794-2675
Justice, David A., Cleburne	463-2298
Marcus, Elliott L., Madison	539-5179
Mardre, Robert B., Jr., Lee	745-4611
Neal, Ralph D., Jr., Clarke	275-3373
Osband, Richard, Jefferson	328-8387
Montgomery, Guy A., Jr., Lee	749-8146
Reaves, John E., Calhoun	237-0371
Russell, Bruce W., Walker	924-3671
Settler, S. Howard, Jr., Macon	727-8492
Skelton, Bennie L., Etowah	546-4611
Stabler, Paul A., Butler	382-2681
Thoroughman, James C., Lee	745-6271
Veach, Everett G., Lee	745-6271
Webb, William A., Lee	745-6271
Finney, James O., Jefferson	934-5187
Payne, Louis T., Tuscaloosa	758-3601
Cezayirli, Cemil, Jefferson	328-0129

County Medical Society Officers For 1970 Announced

Officers for 55 of Alabama's 67 County Medical Societies for 1970 follow:

BALDWIN:—President—Julius Michelson, M.D., Foley; Vice President—Henry C. Mullins, Jr. M.D., Fairhope; Secretary-Treasurer—James L. Rencher, M.D., Fairhope.

BARBOUR:—President—Kenneth C. Yohn, M.D., Eufaula; Vice-President—Nell R. Eppes, M.D., Eufaula; Secretary-Treasurer—James C. Doyle, M.D., Eufaula.

BIBB:—President—William O. Owings, M.D., Brent; Vice President—William H. Weatherford, M.D., Centreville; Secretary—J. Ethel Montgomery, M.D., West Blocton; Treasurer—Cooper Nicholson, M.D., Centreville.

BLOUNT:—President—William R. Sutton, M.D., Blountsville; Vice President—Ira B. Patton, M.D., Oneonta; Secretary-Treasurer—Ira B. Patton, M.D., Oneonta.

BULLOCK:—President—Howard S. Banton, Jr., M.D., Union Springs; Vice President—Sidney A. Cohn, M.D., Union Springs; Secretary-Treasurer—Orizaba Emfinger, M.D., Union Springs.

CHEROKEE:—President—Eugene H. Bradley, M.D., Centre; Vice President—Secretary-Treasurer—Jack Blackwell, M.D., Centre, Ala.

CHILTON:—President—Kent Johns, M.D., Clanton; Vice President—W. W. Rennings, M.D., Clanton; Secretary-Treasurer—J. H. Johnson, M.D., Clanton.

CHOCTAW:—President—George M. Neville, Jr., M.D., Butler; Vice President—James H. Clark, M.D., Butler; Secretary-Treasurer—Virgil S. Gully, M.D., Butler.

CLARKE:—President—William H. Rudder, M.D., Jackson; Vice President—William F. Deshazo, M.D., Jackson; Secretary-Treasurer—Joseph P. Mudd, Jr., M.D., Jackson.

CLAY:—President—William V. Clark, M.D., Lineville; Vice President—George L. Beale, M.D., Ashland; Secretary-Treasurer—George C. Smith, M.D., Lineville.

COFFEE:—President—Horace E. Sanders, M.D., Enterprise; Vice President—L. Bancroft Cooper, M.D., Elba; Secretary—Joseph W. Herod, Jr., M.D., Enterprise; Treasurer—William L. Mitchell, M.D., Enterprise.

(Continued on Page 966)



relieved with MEASURIN® q. 8h. dosage

Double-strength Measurin timed-release aspirin offers a new kind of control for your arthritic patients. Each 10-grain tablet has over 6,000 microscopic reservoirs that release aspirin at a controlled rate—some right away and some later on. This means—fast relief, followed by long lasting relief. Throughout the day, Measurin gives your patients freedom from a 4-hour dosage schedule. Measurin can help your patients get a good night's sleep, uninterrupted by the need for an extra dose of aspirin. And, taken at bedtime, it also helps ease morning joint discomfort and stiffness.

For Professional Samples write:
Breon Laboratories Inc.
Sample Fulfillment Division
P.O. Box 141
Fairview, N.J. 07022

BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016
Subsidiary of Sterling Drug Inc.

MEASURIN®
TIMED-RELEASE ASPIRIN
ECONOMICAL • EFFECTIVE • LONG LASTING PAIN RELIEF
Dosage: 2 tablets followed by 1 or 2 tablets every 8 hours as required, not to exceed 6 tablets in 24 hours. For maximum nighttime pain relief and to help relieve early morning stiffness, 2 tablets at bedtime.
Available: Bottles of 12, 36 and 60 tablets.

(Continued from Page 964)

COLBERT:—President—James A. Mitchell, M.D., Sheffield; Vice President—Thomas L. Pritchett, Jr., M.D., Sheffield; Secretary-Treasurer—Robert E. Campbell, M.D., Sheffield.

CONECUH:—President—Robert W. Stallworth, M.D., Evergreen; Vice President—Cecil E. Price, M.D., Evergreen; Secretary-Treasurer—David E. Owensby, M.D., Evergreen.

COOSA:—President—H. L. Cockerham, Jr., M.D., Goodwater; Secretary-Treasurer—H. L. Cockerham, Jr., M.D., Goodwater.

COVINGTON:—President—Richard J. Spurlin, M.D., Opp; Vice President—Leslie L. Parker, M.D., Andalusia; Secretary-Treasurer—Coleman D. McLeod, M.D., Andalusia.

CRENSHAW:—President—D. V. Vanderhoeven, M.D., Luverne; Vice President—J. C. Ray, M.D., Luverne; Secretary-Treasurer—J. E. Kendrick, M.D., Luverne.

CULLMAN:—President—George T. Rowe, M.D., Hanceville; Vice President—Eugene A. Bownes, M.D., Cullman; Secretary-Treasurer—Everett B. Barnes, Jr., M.D., Cullman.

DALE:—President—George L. Andrews, M.D., Ozark; Vice President—Bascom D. Petrey, M.D., Ozark; Secretary-Treasurer—Robert F. Zumstein, M.D., Ariton.

DALLAS:—President—Perry C. DeBardeleben, M.D., Selma; Vice President—Clyde B. Cox, Jr., M.D., Selma; Secretary-Treasurer—William G. Hood, Jr., M.D., Selma.

DEKALB:—President—Charles A. Isbell, M.D., Fort Payne; Vice President—James A. Walker, M.D., Fort Payne; Secretary—Gerald T. Cochran, M.D., Fyffe; Treasurer—John B. Isbell, III, M.D., Fort Payne.

ELMORE:—President—Ernest O. Majure, M.D., Tallassee; Vice President—Lawrence H. Owsley, M.D., Wetumpka; Secretary-Treasurer—Julius E. Dunn, Jr., M.D., Wetumpka.

ESCAMBIA:—President—Robert E. Low, M.D., Brewton; Vice President—Percy J. Howard, M.D., Atmore; Secretary-Treasurer—Edward F. Goldsmith, M.D., Atmore.

ETOWAH:—President—Edward H. Thompson, M.D., East Gadsden; Vice President—Robert Gillmann, M.D., Gadsden; Secretary-Treasurer—William S. Warren, M.D., Gadsden.

FAYETTE:—President—R. O. Rutland, Jr., M.D., Vice President—B. W. McNease, M.D., Secretary-Treasurer—H. E. Breitling, Jr., M.D.

FRANKLIN:—President—Guy C. Durant, M.D., Russellville; Vice President—Andrew A. Windham, M.D., Russellville; Secretary-Treasurer—Wayne P. Hyatt, M.D., Russellville.

GREENE:—President—J. P. Smith, M.D., Eutaw; Vice President—J. J. Bethany, Jr., M.D., Eutaw; Secretary—W. H. Frederick, M.D., Eutaw; Treasurer—R. L. Staggers, M.D., Eutaw.

HOUSTON:—Roy M. Driggers, M.D., Dothan; Vice President—Rube R. Hundley, M.D., Dothan; Secretary-Treasurer—David H. Pope, M.D., Dothan.

JEFFERSON:—President—James A. Davis, Jr., M.D., Birmingham; Vice President—Gray C. Buck, Jr., M.D., Birmingham; Secretary-Treasurer—Bluitt L. Landers, Jr., M.D., Birmingham.

LAMAR:—President—W. C. Box, Sulligent; Vice President—C. E. Smith, M.D., Vernon; Secretary-Treasurer—W. H. Wright, M.D., Sulligent.

LAUDERDALE:—President—Ranel B. Spence, M.D., Florence; Vice President—Wilford C. Doss, Jr., M.D., Florence; Secretary-Treasurer—James D. McCown, M.D., Sheffield.

LAWRENCE:—President—Willard W. Irwin, M.D., Moulton; Vice President—James

(Continued on Page 968)



The Bradley Center --- for the problems of living

An all new homelike open psychiatric residence on a lovely five-acre tract, centrally located within the community, providing a comprehensive range of continuous services, including in-patient, day care, and outpatient treatment. Each patient participates in an extensive and intensive treatment program, based almost exclusively upon multiple psychotherapeutic encounters. These include individual psychotherapy, group psychotherapy, the nursing milieu, occupational therapy, recreational therapy, topical small group discussions, and other group activities in the Center, as well as in the community, depending on individual needs and interests. Medications are prescribed when appropriate.

Any individual may be admitted who, in the opinion of the medical staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible family member.

Accredited by the Joint Commission on Accreditation of Hospitals.

Leonard T. Maholick, M. D.
Medical Director

Maj. Gen. (ret.) Howard Snyder
Administrator

THE BRADLEY CENTER, INC.
2000 Sixteenth Avenue
Columbus, Georgia 31901
Area Code 404 324-4882

(Continued from Page 966)

A. Ussery, M.D., Courtland; Secretary-Treasurer—Robert H. Rhyne, Jr., M.D., Moulton.

LEE:—President—James E. Walker, M.D., Opelika; Vice President—George E. Fuller, M.D., Opelika; Secretary-Treasurer—Byron S. Knapp, M.D., Auburn.

LIMESTONE:—President—Frank M. Cauthen, M.D., Athens; Vice President—Bruce W. Karrh, M.D., Athens; Secretary-Treasurer—Charles D. Roberson, M.D., Athens.

LOWNDES:—President—W. L. Staggers, M.D., Benton, Vice President—H. H. Meadows, Jr., M.D., Hayneville; Secretary-Treasurer—R. P. Griffin, M.D., Fort Deposit.

MADISON:—President—Harvey M. Pewitt, Jr., M.D., Huntsville; Vice President—Milton B. Peeler, M.D., Huntsville; Secretary-Treasurer—Otis F. Gay, M.D., Huntsville.

MARENGO:—President—Gerald N. Williams, M.D., Linden; Vice President—Robert D. Williamson, M.D., Linden; Secretary-Treasurer—Paul F. Ketcham, M.D., Demopolis.

MARION:—President—Aubrey L. Sewell, M.D., Winfield; Vice President—Ralph C. Christopher, Jr., M.D., Guin; Secretary—Charles R. Pyle, M.D., Hamilton; Treasurer—Ernest A. West, M.D., Hackleburg.

MOBILE:—President—William T. Wright, M.D., Mobile; President Elect—Samuel Eichold, II, M.D., Mobile; Secretary—Gordon E. Carroll, M. D. Mobile; Treasurer—Julian S. Lewis, M.D., Mobile.

MONROE:—President—Rayford A. Smith, Jr., M.D., Monroeville; Vice President—Woodrow W. Eddins, M.D., Monroeville; Secretary-Treasurer—Jack M. Whetstone, M.D., Monroeville.

MONTGOMERY:—President—William B. Crum, M.D., Montgomery; Vice President—Willard D. Bennett, M.D., Montgomery; Secretary-Treasurer—William L. Smith, M.D., Montgomery.

MORGAN:—President—Samuel B. Owens, M.D., Decatur; Vice President—Jolly McKenzie, M.D., Decatur; Secretary-Treasurer—Betty W. Vaughan, M.D., Decatur.

PERRY:—President—Marcus A. Straughn, M.D., Marion; Vice President—Arthur F. Wilkerson, M.D., Marion; Secretary-Treasurer—John R. Long, M.D., Marion.

PICKENS:—President—R. K. Wilson, M.D., Aliceville; Vice President—Jon Sanford, M. D., Gordo; Secretary-Treasurer—J. H. Gentry, M.D., Aliceville.

PIKE:—President—James A. Brantley, M.D., Troy; Vice President—Jesse H. Colley, M.D., Troy; Secretary—James O. Colley, M.D., Troy; Treasurer—Clarence L. Golden, M.D., Brundidge.

RANDOLPH:—President—Willis D. Israel, M.D., Wedowee; Vice President—James R. Simms, Jr., M.D., Roanoke; Secretary-Treasurer—Gerald W. Everett, M.D., Wedowee.

RUSSELL:—President—T. B. Blake, Jr., M.D., Phenix City; Vice President—M. D. Cohen, M.D., Phenix City; Secretary—David T. W. Chi, M.D., Phenix City; Treasurer—J. M. Webber, M.D., Phenix City.

SHELBY:—President—Leslie H. Hubbard, M.D., Montevallo; Vice President—Lewis E. Kirkland, M.D., Montevallo; Secretary-Treasurer—Willie E. Stinson, M.D., Siluria.

ST. CLAIR:—President—Arthur F. Riser, M.D., Pell City; Vice President—Milton G. Norrell, Jr., M.D., Pell City; Secretary-Treasurer—John E. Haynes, M.D., Pell City.

SUMTER:—President—D. P. Hightower, M.D., York; Vice President—T. B. Norton, M.D., York; Secretary-Treasurer—S. J. Williams, M.D., Livingston.

TALLADEGA:—President—Richard F. Bliss, M.D., Talladega; Vice President—Robert M. Gray, M.D., Sylacauga; Secretary—John D. Rayfield, M.D., Sylacauga; Treasurer—Arthur F. Toole, M.D., Talladega.

TUSCALOOSA:—President—W. C. Folsom, M.D., Tuscaloosa; Vice President—T. H. Patton, Jr., M.D., Tuscaloosa; Secretary-Treasurer—G. M. Cooper, M.D., Tuscaloosa.

WALKER:—President—Thomas Payne, III, M.D., Jasper; Vice President—Richard D. Harp, M.D., Jasper; Secretary-Treasurer—Robert E. Ray, M.D., Jasper.

WASHINGTON:—President—John L. Hubbard, Jr., M.D., Chatom; Vice President—Herman C. Patterson, M. D., Chatom; Secretary-Treasurer—Paul W. Petcher, M.D., Chatom.

WILCOX:—President—J. Paul Jones, M.D., Camden; Vice President—James D. Nettles, M.D., Arlington; Secretary-Treasurer—W. R. Anderson, M.D., Camden.

WINSTON:—President—Hobson Manasco, M.D., Haleyville; Vice President—Bennie N. Moore, M.D., Haleyville; Secretary-Treasurer—John E. Wood, M.D., Haleyville.

Ec-
on-
omy!
Dicarbosil®
ANTACID
Your ulcer patients and others will appreciate it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.
ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

Are Physicians Drug-Dumb?

Writes Irving Rubin, R.Ph., editor, in *Pharmacy Times:*

Do physicians continue to prescribe certain drugs—year after year—even though these drugs are ineffective and/or unsafe?

I'd have to answer *Yes*—if I agreed with the Food and Drug Administration's recent stepped-up drive against drugs which practicing physicians have been prescribing for years.

FDA's drive—largely against the products of research-oriented companies—comes at a time when the federal government has announced that the National Institutes of Health is reducing its research grants. Such cuts threaten to close down a number of medical research centers. Certainly, this is *not* the time to pull the rug from under pharmaceutical companies that—the record shows—have been pioneers in research.

Or . . . could it be that the FDA is 100 per cent correct and the nation's doctors are not familiar with the drugs they prescribe? I find it hard to believe that a physician would continue to use drugs—year after year—*if these drugs did not help his patients.* Yet, in effect, that's what the FDA says has been happening.

I don't believe that doctors are drug-dumb. My vote of confidence goes to the nation's practicing physicians and their experience with drugs!

—Journal of the Tennessee Medical Association.

MEDICAL MALPRACTICE PATIENT VS. PHYSICIAN

For several years the number of malpractice claims in the United States has steadily increased. The size of malpractice judgments has increased substantially faster than any other segment of our economic picture.

Sen. Abraham Ribicoff's Subcommittee on Executive Reorganization has been studying the medical malpractice litigation problem since February, 1969. This Committee has sought the reasons behind the apparent rise in the number of law suits. It sought to find out whether malpractice litigation was an indication of the quality of malpractice. The Committee further explored the Federal Government's role in malpractice activities.

After exploring this problem for nine months, the Committee came to the following conclusions:

(1) The number of malpractice suits and claims is rising sharply in certain regions of the United States. The size of judgments and settlements is increasing rapidly.

(2) Most malpractice suits are the direct result of injuries suffered by patients during medical or surgical treatment. The majority are justified. These suits are the indirect results of a deterioration of the traditional physician-patient relationship.

(3) The publicity surrounding higher malpractice judgments and settlements tends to trigger litigation in other states. A National crisis over the malpractice situation is threatened.

(4) Higher judgments and settlements cause:

a. Companies providing malpractice insurance to increase premiums

b. these costs to be passed on to patients in the form of higher physician fees.

(5) Physicians are forced to practice defensive medicine often ordering excessive diagnostic tests, etc.

(6) No one concerned is presently effectively working on a solution that promises to alleviate this situation.

(7) Lawyers are getting the lion's share of proceeds from malpractice suits and claims.

(8) The Committee concluded that there is a definite Federal role in the malpractice problem.

How To Avoid Malpractice Suits

The total number of malpractice suits filed and claims pending in Alabama is not known, however, H. F. McJenkins, General Manager of Aetna, recently told the Insurance Committee of the Medical Association of the State of Alabama that 37 malpractice suits are pending against Alabama physicians totaling $8 million. Aetna is the professional liability insuror of over 54 per cent of the Alabama physician population.

Many reasons are advanced for the increase in malpractice litigation. Among these are:

(1) Public Attitudes—The public has been lead to expect miraculous results from medical and surgical treatment without being fully aware of the serious and unexpected complications that sometimes result.

(2) Juries—Higher judgments in personal injury and professional liability cases are being awarded by juries each year.

(3) Inflation—Judgments tend to increase as the value of the dollar decreases.

(4) Courts—Some courts are extending plaintiff favoring rules of evidence, i. e., res ipsa loquitur.

(5) Attorneys—Plaintiff attorneys are becoming more proficient in malpractice trial technics.

(6) Increasing Hazards of Medicine and Surgery—Medicine is becoming more complex each year.

In spite of these trends, physicians can take positive steps to avoid becoming defendants in malpractice actions. Crawford Morris, prominent defense attorney, said in a recent issue of "The Physicians Legal Brief" that a physician should consider these points:

(1) The physician usually can decline to accept a patient. However, Mr. Morris cautions the physician, that while he has an option to step aside, he must do so before he places himself in a position of abandoning the patient.

(2) Never guarantee a cure. The physician who promises a cure or uses language intimating such promise can be sued, not only for negligence, but for breach of contract as well, if the promised results do not materialize.

(3) Watch the time factor, especially if there has been an unfortunate result. This rule relates to the Statute of Limitations which vary in each state.

(4) Keep up with the advances in medicine. A physician will be judged by what is considered good medical care at the time he renders treatment.

(5) Do not use unnecessary experimental procedures. If a physician finds such procedures necessary, he should announce it frankly as such and obtain a written informed consent for the procedure.

(6) Make a simple, reasonable disclosure of the risks involved, unless there is a therapeutic reason for not telling the patient. In these instances it is advisable to tell the patient's relatives, but obtain an informed consent from the patient for everything done.

(7) Keep good records. Should a trial ensue, records are important because they are admissible as evidence, while witnesses to an event may not be available.

(8) Cooperate with the medical profession. This rule is laid down in an effort to caution physicians against "loose" talk which can promote law suits.

(9) Do not be hesitant about consultation. Mr. Morris cited a case he tried and won because there were numerous consultations in an effort to make a correct diagnosis. The diagnosis was incorrect, but the best men in town were called in for consultations which refuted a claim that the physician's conduct was negligent.

(10) Maintain good public relations. Mr. Morris noted that physicians should "be as careful with your tongue as you are with your scalpel." Incidents, in which patients overhear comments about their conditions, can constitute inferior medical practice, as well as poor public relations, and are apt to promote law suits.

Setting A Good Example

Lung cancer, emphysema and heart failure are already high prices to pay for cigarette smoking. Any hanky-panky that misleads our young non-smokers to believe "the TV stars do it, why not me" and makes their starting the use of cigarettes more defensible should not be tolerated. Any television performer (already a smoker) should be able to forego the pleasure of that form of self destruction until his show is over. Then he DOES NOT become an example to those who should quit and, especially, those who should never start.

—St. Louis County
Medical Society Bulletin

Safety In Flying Lies In More Flying, A Flying Doctor Declares

In this nuclear age, when lightning-fast destruction hovers over the globe, medicine with wings is a reassuring thought.

This, plus some physicians' love of higher adventure, brought into being, less than a decade and a half ago, the Flying Physicians Association, which was incorporated under the laws of the State of New York as a "not-for-profit, scientific, educational society" in October, 1955.

Today it still numbers in the 50 states less than the membership in the Medical Association of the State of Alabama. But its encouragement of doctors to fly, underscoring safety in an area where flying is particularly hazardous, is a fact recognized even by the more numerous physicians who have not bothered to qualify for the ringed-and-winged staff of Aesculapius that is the insignia of the FPA.

Paul Daley Everest, M.D., Montgomery orthopedic surgeon is an illustration in point. He was still four years on the right side of 50 when he took a plane alone into the wild-blue-yonder, lifting it from the adequate runways of Dannelly. Today a more enthusiastic member of the Flying Physicians Association would be hard to imagine.

Today he has his instrument rating and is working on his commercial license. He flies everywhere, usually with his wife Peggy in the co-pilot's seat as navigator. In a partnership arrangement with a friend he is half owner of a Piper Cherokee 235.

Paul Everest was born in Washburn, Wis., May 24, 1920, and received his M.D. degree from the University of Wisconsin 25 years later. Five of his friends had become pilots in World War II and his passion for flying was born then, just as his liking for the South would be born with his military service. His introduction to the South came with his Army assignment to Oliver General Hospital in Augusta, Ga.

(And parenthetically, Oliver General Hospital is named for the father of a career Air Force officer, Brig. Gen. Robert Chaffee Oliver, West Point Class of 1923, who served a tour of duty at Maxwell AFB before taking over a command in the China-Burma-India theater in World War II, and whose wife and son lived in Montgomery during his service overseas).



Dr. Paul Everest with his Cherokee.

Dr. Everest is married to the former Margaret Close of Oak Park, Ill. And they have three children: John, 22, and Carol, 20, both students at the University of Alabama, and 15-year-old Margaret at the Montgomery Academy.

He learned flying under the tutelage of Richard Miller at Montgomery Aviation, and his instrument instruction came from Ralph Wiles, a Marine pilot whose picture, appeared last month beside another of his pupils, Dr. Dan S. Hagood, Montgomery.

With one notable exception, flying is particularly hazardous for professional men (whether they be doctors, lawyers or what-not). The exception in the medical profession, Dr. Everest will point out to you, is membership in FPA, where the need for annual check rides is heavily underscored. "The danger to flying is *not* flying enough," he will tell you, and he has the statistics to prove it.

Alabama Department of Public Health

Registered Nurse Utilization—A Key To Improved Patient Care

The registered nurse spends more time in non-nursing activities than she does in patient care according to a study of registered nurse utilization in Alabama. The study further indicated that only about 20 per cent of all nursing personnel time is actually spent in direct patient care as registered nurses are responsible for many functions which are not direct patient care.

The committee which reported these findings was initiated by the Alabama League for Nursing with the purpose of seeking ways to improve patient care. The committee includes physicians, administrators, a systems and industrial engineer, and nurses from institutions, public health agencies, and nursing education.

In assessing the nursing needs in Alabama the committee compiled answers to the following questions:

(1) How many nurses are registered in Alabama?

(2) How many are employed in nursing?

(3) If not employed, why not?

(4) Where are nurses employed?

(5) What does the registered nurse do? Are her knowledge and ability being used for patient care?

(6) How have advances in health care knowledge affected nursing?

The compiled responses to a survey questionnaire which answer these questions are revealing, and on the basis of these the committee was able to make recommendations for better nurse utilization in Alabama.



Mrs. Frances Russey, President, Alabama League for Nursing, presents first copy of nurse utilization study to Larry Corcoran, confidential assistant to governor.

According to the study there is a total of 6,897 employed nurses and 1,581 unemployed. Only Arkansas, Mississippi, and Georgia are reported to have fewer nurses per 100,000 population than Alabama. While some nurses have returned to part or full time work after taking Alabama Nursing Association refresher courses, there is limited potential for alleviating the shortage by this method. The study further indicates that the per cent of RN's in total nursing staff is well below the 50 per cent recommended by American Hospital Association studies.

In response to the question, "Where are nurses employed," the study reveals that the largest number is employed in institutions (hospitals and nursing homes). The next largest group is office nurses, then private duty nurses, and public health nurses are in fourth place.

Comparing public health with national

figures, Alabama has 8.7 public health nurses per 100,000 population, the lowest number for any state. This causes particular concern among public health people who wonder what effect this shortage will have on Medicare, Medicaid, and other public health nursing programs. If the demands of these programs become greater, where will the additional nurses be found to fulfill these demands?

One of the more startling revelations of the study is related to the duties of the registered nurse. Although the nurse is strongly motivated in her choice of vocation by a sincere desire to understand and to help people, the actual time spent by nurses in direct patient care has dwindled to 20 per cent.

There are several reasons for this. For one thing, there are a number of supportive activities which the nurse has traditionally done throughout the history of nursing. These are activities that are, by necessity, learned on the job and are not included in academic preparation. The committee questioned if these activities should continue to be nurses' responsibilities in view of their more complicated delivery of health care. In addition to this, many new procedures have been added and/or transferred from physician to nurse. The reasons for the transfer are the perfection of equipment, the ease of teaching the procedure, and the frequency with which it is done. Many times these activities are added to the nurse's already busy schedule without subtracting from what is expected of nursing. Too, the change in the philosophy of health care from "secrecy" to "tell all" and teaching patients about their health problems in order to control or prevent illness has added to the demands on the nurse's time.

As a result the quality of patient care has suffered. The responsibilities of the registered nurse have been increased by the variety of procedures to be done, the amount of equipment and supplies necessary, the system of patient charges, and the number of people the nurse is expected to teach and supervise. Therefore, the span of control over the people and things expected of nurses is far beyond any management recommendation.

In its recommendations to hospital administrators, public health officials and nursing supervisors, the committee asks that:

Registered nurses be relieved of all activities other than those related to direct patient care, management and teaching of patients and nursing personnel who assist in direct patient care.

—Institutions offer sufficient in-service education for nurses.

—Effective in October 1973 registered nurses be required to show proof annually of 12 hours of continuing education in order to maintain registration.

—Nurse representation be provided on all committees which deal with patient care.

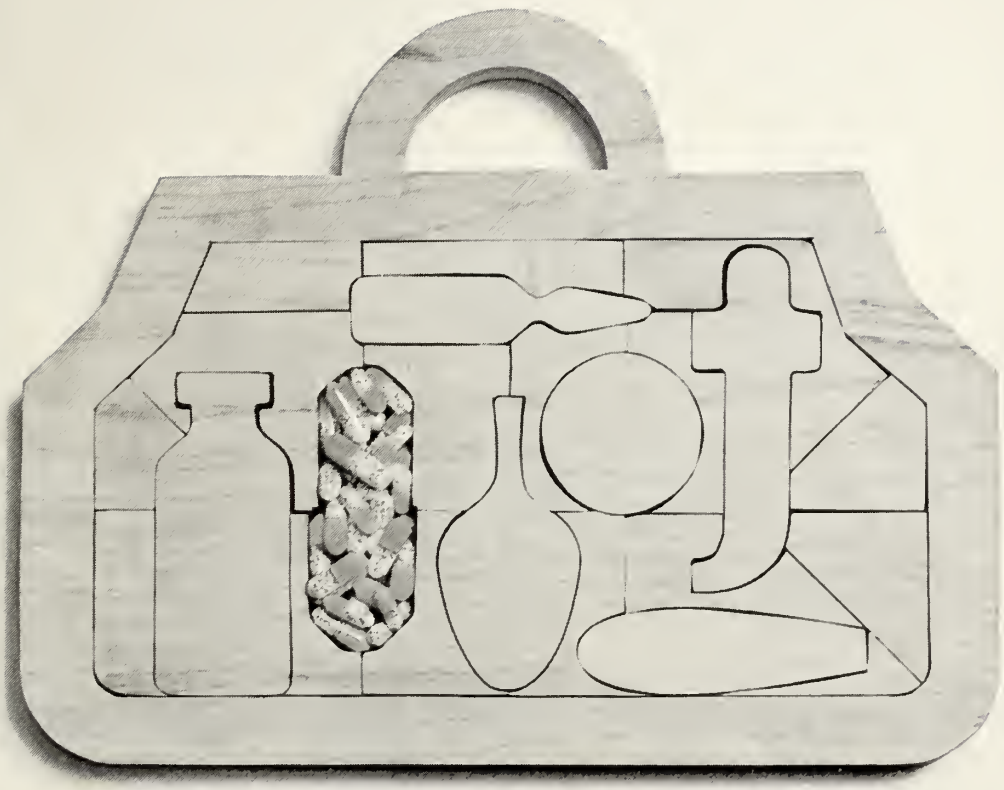
—Nurses be provided immediately accessible support services such as housekeeping, pharmacy, central service and dietary.

In its conclusion the committee says it feels the quality of patient care in the state can be improved with the nurses now available if they are freed of the non-direct patient care activities.

"This change in the 'system' will require cooperation of all departments in institutions and agencies and the development of understanding and willingness of nurses to limit their efforts to these direct patient care activities," the report says.

Subject: "Hypertension"

"Hypertension" is the subject of the Ninth National Symposium of the Heart Association of Southeastern Pennsylvania to be held at the Sheraton Hotel, Philadelphia, Feb. 12-13. Several important speakers have been obtained for the event, according to Robert L. Kunes, Director of Public Information.



One of seven dosage forms

Thorazine®

brand of chlorpromazine HCl

Spansule®

brand of sustained release capsules

Available in 30 mg., 75 mg., 150 mg., 200 mg and 300 mg strengths.

Smith Kline & French Laboratories
Philadelphia, Pa. 19101

INDEX TO ADVERTISERS

Arch Laboratories 969

Blue Cross-Blue Shield 957
The Bradley Center 967
Breon Laboratories 965
Burroughs Wellcome 894

Campbell Soup 929
Classified 950

Dow Chemical Company 961

Geigy Pharmaceuticals 893, 896, 897
Glenbrook Laboratories ..... 3rd Cover
Guest House Motor Hotel 958

Highland Hospital 950
Hoechst Pharmaceuticals 899
Hynson, Westcott & Dunning 887

Lederle Laboratories 889, 978
Eli Lilly & Company ..... 1st Cover, 912

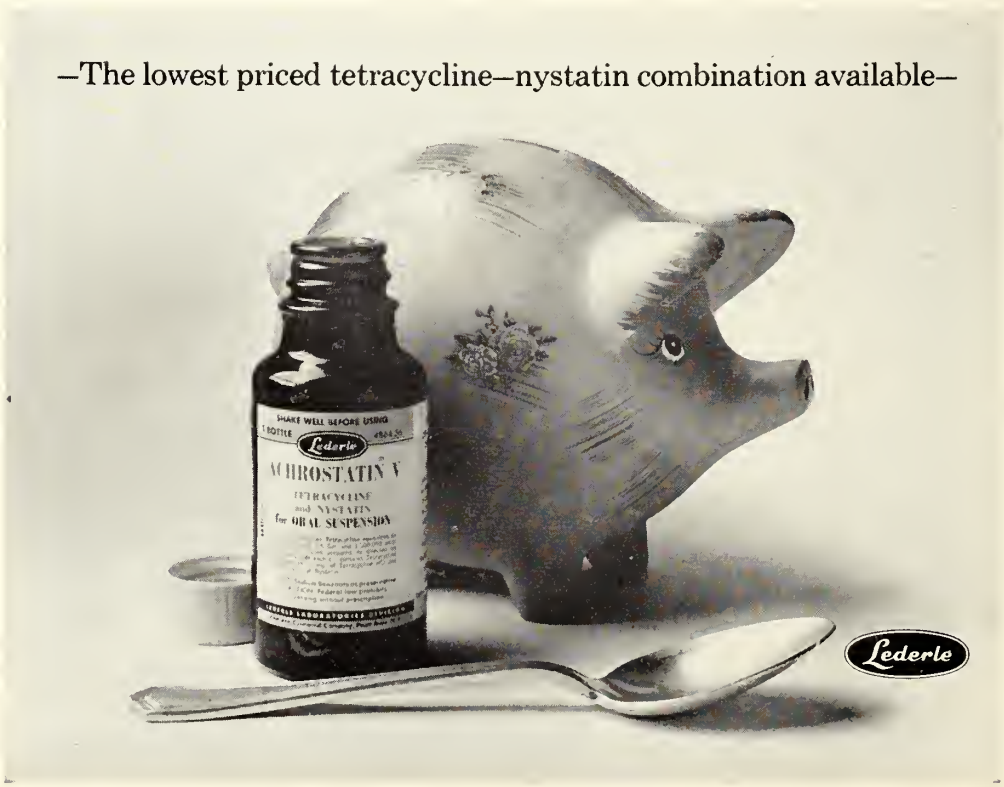
Mid-South Medical Association 955
Merrell Company 944

National Drug Company ..... 2nd Cover, 951, 952

Wm. P. Poythress & Company, Inc. 895

A. H. Robins Company 901, 932, 941, 942, 962
Roche Laboratories ..... 939, 963, 4th Cover

Julius Schmid, Inc. 948, 949
G. D. Searle 930, 931
Smith Kline & French 977





"All Interns are Alike"

ands to reason. They all go through the same train-
. they all have to pass the same tests; they all have
measure up to the same standards; they all are
erpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more
sensical than what some people say about aspirin.
nely: since all aspirin is at least supposed to come
to certain required standards, then all aspirin
ets must be alike.

Bayer's standards are far more demanding. In fact,
e are at least *nine specific differences* involving
ty, potency and speed of tablet disintegration.

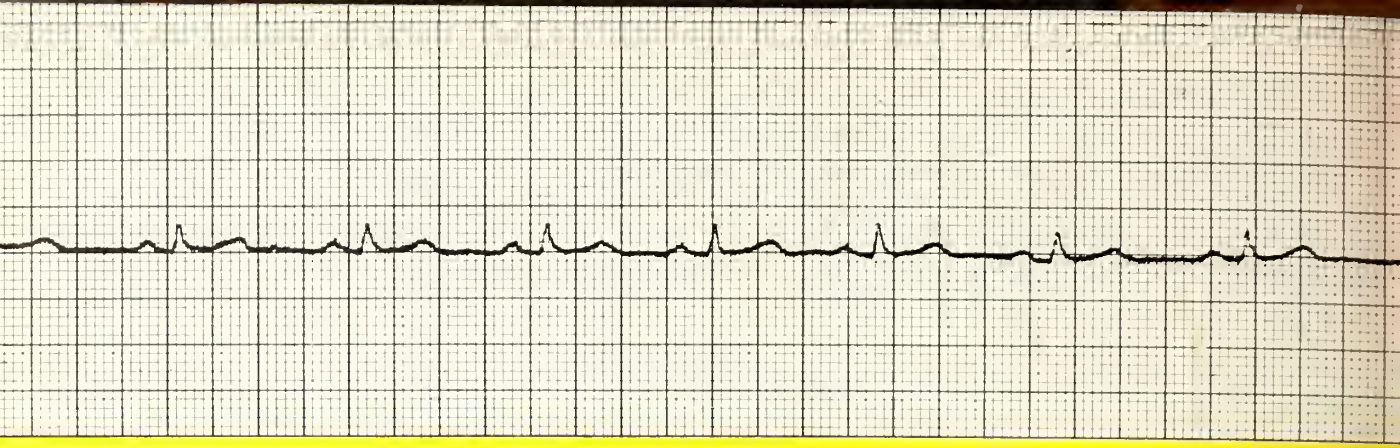
These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.







When disease is ruled out and psychic tension is implicated

Valium® (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

PICTURE REPORT ON ANNUAL SESSION
PAGES 993, 994, 995, 996

JOURNAL of the Medical Association of the State of ALABAMA

DISPLAY SHELVES

IN THIS ISSUE

The Psychology of the Tuberculous Patient . . 1011
A Patient Speaks 1016
Volunteers and Tuberculosis 1021

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON
2 JUN 1970



TES-TAPE®
Urine Sugar Analysis Paper

Snip, dip, compare—that's all

An easy, accurate test-paper method for the qualitative and semiquantitative determination of urine glucose

Additional information available upon request.

Lilly Leadership in Diabetes Research for Half a Century

Eli Lilly and Company • Indianapolis, Indiana 46206
000118

Exchange Office
Francis A. Countway Lib. of Medicine
10 Shattuck St.
Boston, Massachusetts 02115

MAY 1970

The girth control pill



Tepanil® Ten-tab®
(continuous release form)

(diethylpropion hydrochloride)

works on the appetite not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-006A / 1/70 / U.S. PATENT NO. 3,001,91

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 1914

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON
JUN 1970

Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

■ LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be useful by many clinicians in controlling abnormal uterine activity.

■ Literature on indications and dosage available on request.

■ No side effects have been reported, even when massive doses (25 tablets per day) were administered.

■ Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. BALTIMORE, MARYLAND 21201

(LTR23)

THE JOURNAL

of the

Medical Association of the State of Alabama

Volume 39 • May, 1970 • No. 11

Office of Publication
19 So. Jackson St. Montgomery, Ala. 36104
Subscription Price $5.00 Per Year
$1.00 Per Copy

Second Class Postage Paid at Montgomery, Alabama. Published monthly in Montgomery at 19 South Jackson Street.

Editor-in-Chief
William L. Smith, M. D. Montgomery

Managing Editor
L. P. Patterson Montgomery

Assistant Managing Editor
Mary Nell Williford Montgomery

Associate Editors
J. P. Collier, M. D. Tuscaloosa
John M. Chenault, M. D. Decatur
M. Vaun Adams, M. D. Mobile

Officers of the Association

President
S. Buford Word, M. D. Birmingham

President-Elect
A. E. Thomas, M. D. Montgomery

Vice-Presidents
F. M. Phillippi, Jr., M. D. Brewton
J. E. Cameron, M. D. Alexander City
O. Emfinger, M. D. Union Springs
Wood S. Herren, M. D. Birmingham

Secretary-Treasurer
William L. Smith, M. D. Montgomery

Executive Director
L. P. Patterson Montgomery

The State Board of Censors
John M. Chenault, M. D., Chmn. Decatur
J. P. Collier, M. D. Tuscaloosa
Paul W. Burleson, M. D. Birmingham
L. L. Hill, M. D. Montgomery
M. Vaun Adams, M. D. Mobile
J. D. Bush, M. D. Gadsden
E. L. Strandell, M. D. Brewton
John W. Davis, Jr., M. D. Montgomery
J. Garber Galbraith, M. D. Birmingham
H. G. Hodo, M. D. Fayette

State Health Officer
Ira L. Myers, M. D. Montgomery

Delegates and Alternates to the American Medical Association

(Terms expiring December 31 of year shown.)

1970
Delegate—E. Bryce Robinson, Jr., M. D., Fairfield
Alternate—W. E. White Anniston

1971
Delegate—M. Vaun Adams, M. D. Mobile
Alternate—E. L. McCafferty, Jr., M. D. Mobile
Delegate—P. W. Burleson, M. D. Birmingham
Alternate—Robert Parker, M. D. Montgomery

CONTENTS

President's Page 982

The Woman's Auxiliary 984

Editorial Comment 986
- Medicine Labors Against Its Own Survival 986
- The Precise Price of Man's Survival Is Yet To Be Decided 987
- When, If Ever, Does A Young Man Become Old? 987
- Only For The Patient's Benefit 991
- Is Spreading Narcotics Use Triggering A Nation's End? 991

Pictcrial Highlights Of The 109th Annual Session 993

Legal Page 999
- The Doctrine Of Res Ipsa Loquitur 999

The Month In Washington 1004

Scientific Section 1011
- The Psychology Of The Tuberculous Patient, Verna Wool, Ph. D., Montgomery 1011
- A Patient Speaks, Mrs. Louise Nachman 1016
- Volunteers And Tuberculosis, K. W. Grimley 1021

Around The State 1029
- New Physicians Licensed To Practice In Alabama 1029
- 12 County Societies Unreported Last Month 1030
- Vital Statistics 1031

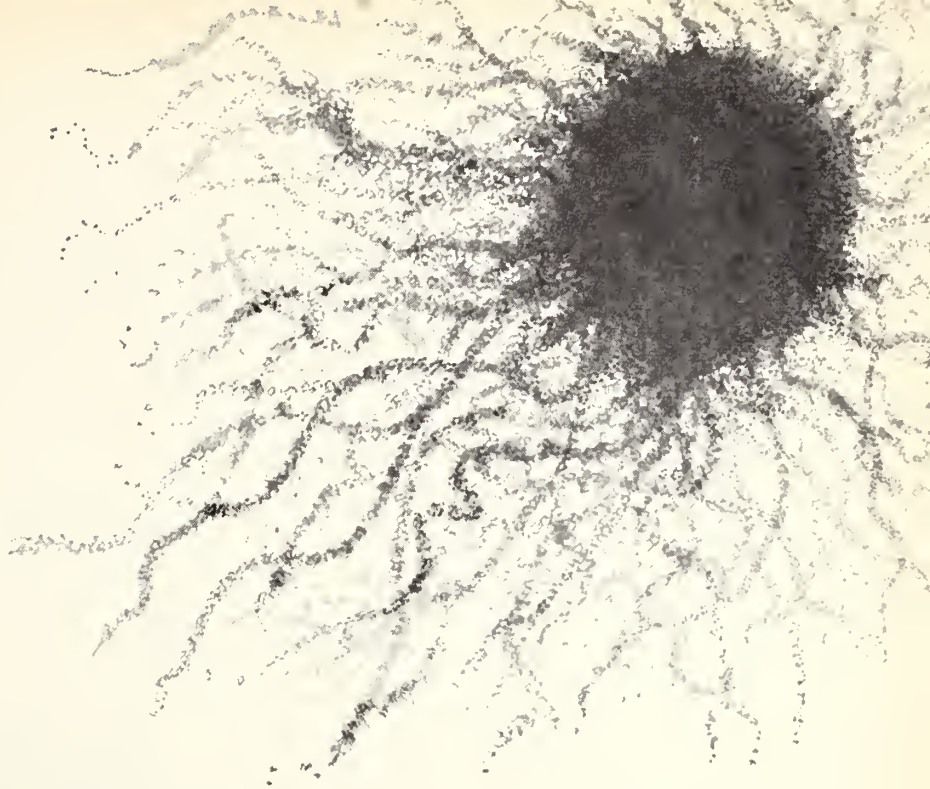
Hcbbies To Fill A Doctor's Leisure 1047
- While His WAMASA Partner Relaxes With A Good Book 1047

Association Forum 1051
- Health Problems In Colonial Alabama, Milo B. Howard, Jr. 1051

Fathers And Sons In Medicine 1058
- Lexingtcn To Montgomery—Three M. D. Generations 1058
- Spanning 80 Vital Years In Alabama History 1064

Millions May Go To Stimulate Family Medicine 1069

From Walking To Wings In Less Than A Century Of Medicine 1071



Corticosteroid therapy week after week.

then antibiotic therapy last week.

and monilial overgrowth this week.

For many patients on long-term corticosteroid therapy, the addition of oral antibiotic therapy may trigger monilial overgrowth in the intestine. When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin—it helps avoid monilial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

it doesn't let monilia begin where bacteria end.

Declostatin® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units Capsule-Shaped Tablets Lederle

Effectiveness: Because its antibacterial [illegible] is DECLOMYCIN® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects. Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes, a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 448-9

President's Page



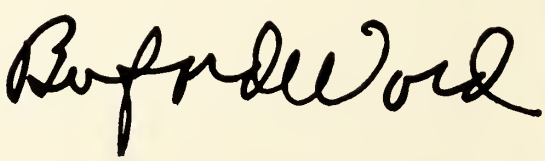
S. Buford Word, M. D.

"How good . . . it is for brethren to dwell together in *unity!*" (Psalms 133:1)

When I first entered practice, Doctor James S. McLester, then known and respected from coast to coast and held in high esteem by his colleagues here in Alabama, said to me, "Son, stick with organized medicine." He spoke with the confidence of a man who had seen the future and knew it would work. It is not my intention to bemoan the past. No one desires to return to the days of "606" in medical practice. I am more desirous of arousing your interest and active participation in the future of organized medicine. No one can divine that future but I believe it will work.

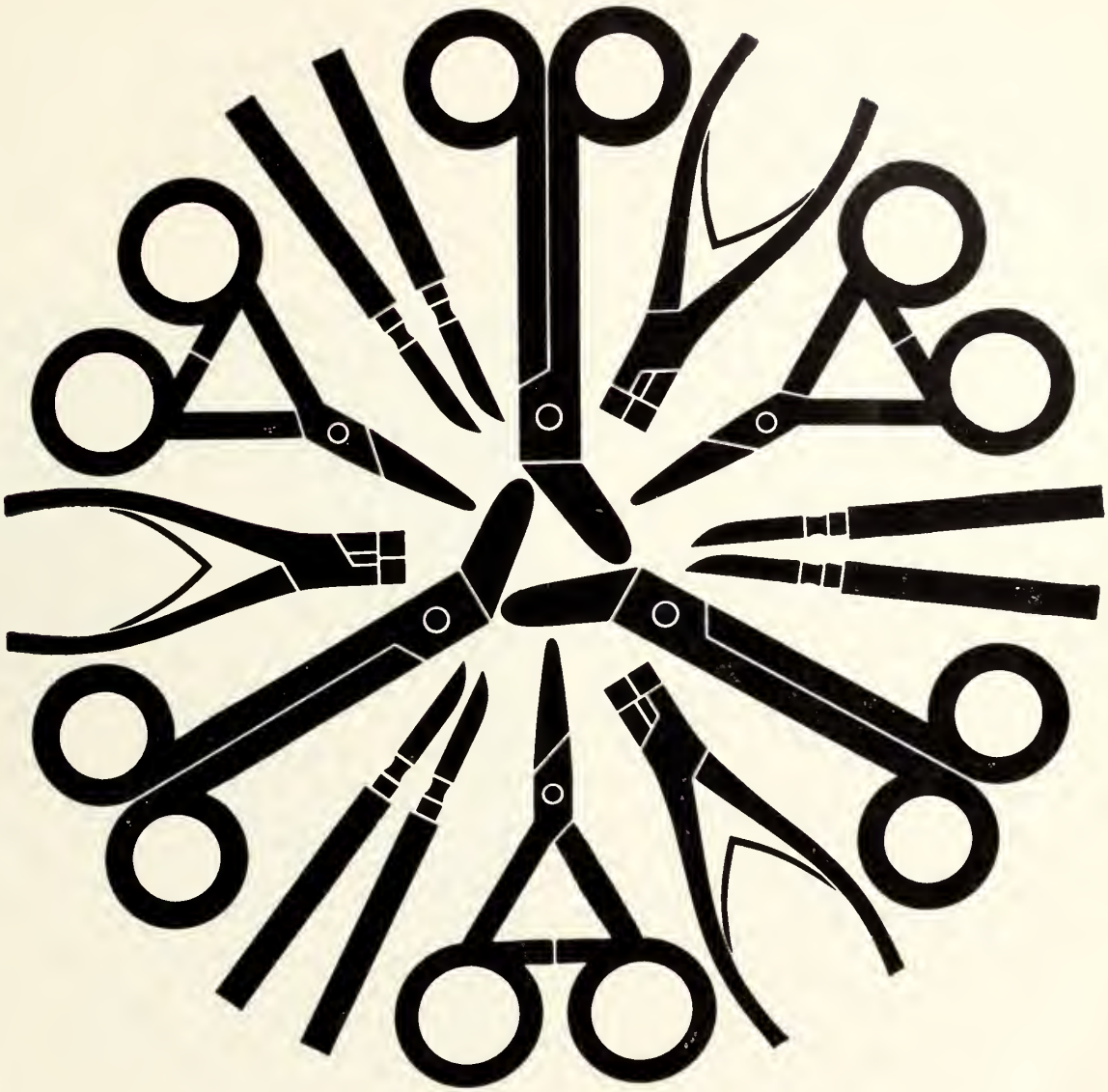
To borrow thoughts from a speech by a recent Prime Minister of the British Empire I would like to tell you, I did not become President to liquidate the Medical Association of the State of Alabama. Winston Churchill's immortal words aroused the entire world. Ours is a different kind of battle. It is never ending. Our role as physicians in medical practice, teaching, research, administration or planning is one of striving for excellence. It is an endless journey that demands continuously our best effort. The physicians of the State are, by law, guardians of the health of its citizens. We should take pride in this fact and preserve it with a degree of jealousy by more active participation in the affairs of our Association. Your Medical Association is like an umbrella under which many groups and individuals work, hopefully, developing better Health Care Programs for the future. You are urged to participate.

I am humbled and awed by the responsibilities I have assumed, but not unproud of the honor. The future does work. It will work better if we dwell together in *unity.*



S. Buford Word, M. D.

before and after surgery



Berocca®

TABLETS
high potency B-complex and C
for nutritional support

AVAILABLE ONLY ON Rx

contains water-soluble vitamins only

b.i.d. dosage

good patient acceptance

no odor, and virtually no aftertaste

Each Berocca Tablet contains:

Thiamine mononitrate	15 mg
Riboflavin	15 mg
Pyridoxine HCl	5 mg
Niacinamide	100 mg
Calcium pantothenate	20 mg
Cyanocobalamin	5 mcg
Folic acid	0.5 mg
Ascorbic acid	500 mg

Usual dosage is one tablet b.i.d.

Indications: Nutritional supplementation in conditions in which water-soluble vitamins are required prophylactically or therapeutically.

Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B_{12}.

Dosage: 1 or 2 tablets daily, as indicated by clinical need.

Available: In bottles of 100.

ROCHE

Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

The Woman's Auxiliary

President, Mrs. Howard C. Johnson
President-Elect, Mrs. Gilder Wideman
Northeast District Vice President, Mrs. James D. Holliman, Jr.
Northwest District Vice President, Mrs. George Hansberry
Southeast District Vice President, Mrs. D. S. Tysinger
Southwest District Vice President, Mrs. Watson Maxwell
WAMASA Editor, Mrs. William L. Smith

AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the Medical Association of the State of Alabama. I will support its activities, protect its reputation and ever sustain its high ideals."



Mrs. Howard C. Johnson

It is indeed a distinct honor and privilege to serve as President of the Woman's Auxiliary to the Medical Association of the State of Alabama for the coming year. I accept the responsibilities that go with this honor with great humility realizing the faith and confidence your wives have placed in me. By the same token, I have the utmost faith and confidence in them, and know that together we can achieve what none of us could do alone.

I promise to serve the Auxiliary to the best of my ability being ever mindful of the high ideals, principles, and standards for which it has stood for so many years.

The primary purposes of the Auxiliary are to assist you, our husbands, in your objectives, and to be worthy citizens of our communities. It is a privilege to belong to the Auxiliary. Though many of us belong to other organizations, it is only through our Auxiliaries that we physicians' wives can meet together with common bonds, interests, and concerns regardless of our husbands' hospital affiliations or medical specialties. We are fortunate in having an Auxiliary organization available to us as a means through which we can contribute to the betterment of our communities' health. Let me take this opportunity to extend to every physician's wife, who is eligible and not a member of the Auxiliary, a cordial invitation to join with us, and share in our rewarding projects and friendships.

Membership is the backbone and life blood of any organization. I am delighted to tell you that during the past year, two more counties have joined our ranks of "helping hands." Autauga County joined with Montgomery County, and will be known as the Montgomery-Autauga Auxiliary. On March 10, 1970 the doctors' wives of Lee County organized an Auxiliary. The ladies of both counties are charming, enthusiastic, and display a tremendous interest in the Auxiliary's program.

Since this is an election year, I hope you agree that we, your wives, must become more active and knowledgeable in the legislative actions of our city, our county, and our state. We must know which candidates are friendly toward organized medicine, and back them with our voices, our physical work, and

money. Only through concerted effort and full knowledge of the issues can medicine remain free. It has been the pastime of some of the American Press for the past several years, to attack the medical profession giving only a one-sided picture. Members of the Auxiliary are anxious to do whatever is necessary to give the other side of the picture, and therefore put the doctors' image back in focus.

The medical profession's increasing concern about the rapidly expanding need for more health manpower underscores Health Careers and the AMA-ERF Guaranteed Loan Fund as priority projects this year.

Other programs being given special emphasis are Community Health and Safety-Disaster Preparedness. All phases of the Auxiliary program are important, and I will give you progress reports from time to time.

It will be a task to even try to fill this chair of Presidency where so many great and dedicated women of Alabama have sat before, but I pledge my loyalty to the Medical Association of the State of Alabama, and to its Auxiliary. May all our endeavors show that we try to enhance and to preserve the decency and dignity of all mankind.

Sincerely,



Camille Johnson

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: MRS. ELIZABETH HARKINS, ACSW, *Coordinator of Admissions*

or

SAMUEL N. WORKMAN, M. D.
Chief of Clinical Services

CHARLES W. NEVILLE, JR., M. D.
Assistant Professor of Psychiatry and Medical Director

Area Code 704 - 254-3201



Medicine Labors Against Its Own Survival

A job is a job is a job, is the way a popular writer of the first half of the 20th century might have put it.

And if she is right (by present day standards of excellence, when everything is equal), then the same may be said for the practice of medicine.

A job is a job is a job, and medicine will have become a commodity to be juggled on the open market, its price determined by where you live:

In a totalitarian state (whether it parades under the banners of nazism, fascism, socialism or communism), government will fix the price.

In a republic, under a free enterprise system, the price of medicine will be determined by the simple rules of supply-and-demand.

Unhappily for the egalitarian, quality enters the picture under a free enterprise system, and the price of quality must always soar beyond the reach of the masses.

The only answer to that is to legislate against quality. Which is nothing new. Legislation against quality has been going on for a long time in other commodity fields. Examine any labor-union contract and see how the pace of production is set by the slowest, most inefficient member of that union. Explore the grammar-school classroom of the Deep South and find how the old measures of excellence now clog the incinerator. And sit in the galleries of your Legislature to watch the continuous parade of bills aimed at elevating chiropractic to the status of the internist, the pediatrician, and the surgeon.

Nearly a century ago, James Bryce, British jurist, historian, and diplomat, remarked: "Medicine is the only profession that labors incessantly to destroy the reason for its own existence."

Since his day, medicine has become the miracle of the ages. Longevity has become commonplace. The average life span is being stretched continually. Diseases that once decimated the world have been conquered. Others are yielding ground. And with oxygen, blood transfusions and organ transplants, death itself is in retreat.

And how much of it came out of mass-produced health, out of socialized medicine?

The Precise Price Of Man's Survival Is Yet To Be Decided

What's your life worth?

There's the story of the wealthy, eccentric and close-fisted Alabama lumber-mill owner who leaned too far over the water to inspect the loose-floating logs. When he fell in and the logs closed over his head, a giant workman leaped after him, pried the logs apart, and pulled the sputtering victim out. Recovering his breath, the mill owner reached in his pocket and tipped his rescuer a dime.

For days afterward fellow workmen kidded the giant unmercifully, until one day the exasperated one exclaimed: "Shut yo' mouth, boy! Mr. Ben knows what his life's wuth!"

The free-enterprise system, which rose on the ashes of the cast system of the Middle Ages, insists that a person is free to sell his work or his product to any buyer he can find for as much as he can get the buyer to pay. In the same way, any person is free to go into the market and buy labor or products if he is willing and able to pay for them.

If Mr. Ben's rescuer had held his employer in the water long enough to bargain with him, he would have come out with much more money than a dime. That is the success secret of strikes. It is the reason why medicine is so helpless in the face of increasing regulatory pressures. Its own code of ethics, born two millenniums ago with the Hippocratic Oath, prevents medicine from withholding the cure until a bargain is struck.

Medicine's battle against disease and death must continue until when the profession becomes obsolete, extinct, or until Government decides just what Mr. Ben's life is worth.

When, If Ever, Does A Young Man Become Old?

How old is old?

The late Frank P. Glass, twice publisher of The Montgomery Advertiser and in between those times co-publisher with the late Victor Hanson of The Birmingham News and publisher of the St. Louis Star-Times, once was infuriated by a news article that referred to a 75-year-old man as "aged." Mr. Glass was *not* "aged" at 75.

An article in *Today's Health,* popular AMA magazine, quotes a New York physician, Irving S. Wright, M. D., as insisting that:

"Biological age, not calendar age, should be used in deciding when a person should retire. Putting a man out to pasture at 65—simply because he is 65—is an outmoded idea and should be abandoned by many employers."

Dr. Wright, who is clinical professor of medicine emeritus at Cornell University Medical College, defines a "biologically young" person as one who has "The ability to conceive, initiate, adopt, activate, and operate new ideas—including those of others—however a radical departure they may appear in terms of existing concepts."

Which brings us to the month of May, and the origin of its name. Popularly this elderly month of the Roman calendar, originally the third of the year, is supposed to have been named for Maia, the Roman goddess of spring and growth. But more and more scholars are insisting that, just as June was originally sacred to the *juniores,* or young men, so May was a month sacred to the *majores,* or older men.

As medicine continually stretches the limits of longevity, it is appropriate to repeat the question with which this piece opened:

How old is old?

(Continued on Page 991)


Pfizer
100
real broad spectrum,
including
susceptible strains of
Pneumococcus*
"Staph"* "Strep"*
H. influenzae*
M. pneumoniae (PPLO)*
N. gonorrhoeae*
low incidence
of diarrhea
outstanding record
of clinical success
therapeutic blood levels
usually persisting
around-the-clock
24



high tissue levels

unlike other tetracyclines can be given with milk or meals

The effectiveness you need.
The advantages you look for.

Vibramycin® (doxycycline)

a semi-synthetic tetracycline

*Because not all strains of pathogens are susceptible, it is recommended that routine culture and susceptibility studies be performed. When using Vibramycin (doxycycline) in streptococcal infections, therapy should be continued for 10 days to prevent the development of rheumatic fever or glomerulonephritis.

See Brief Summary on next page for information on side effects and contraindications.

Pfizer LABORATORIES DIVISION
New York, N.Y. 10017



and convenience too.



The unique new Vibramycin (doxycycline) V-Pak is especially convenient for use both in your office practice and in the hospital outpatient department. It contains a typical four-day course of therapy for routine infections with easy-to-understand patient instructions. The dosage is low, just 100 mg. b.i.d. the first day followed by 100 mg. once a day for the next three days. In more severe infections, 100 mg. q.12 h. is recommended. If renal impairment exists, lower than usual doses are indicated.

And for added convenience in the hospital pharmacy, Vibramycin is available in unit-dose packs of 100 (10 x 10's) for both the 100 mg. and the 50 mg. capsules.

VIBRAMYCIN® (doxycycline)
BRIEF SUMMARY

Contraindicated: In individuals who have shown hypersensitivity to doxycycline.

Warnings: The usual dosage and frequency of administration of Vibramycin (doxycycline) differs from those of other tetracyclines. Exceeding the recommended dosage may result in an increased incidence of side effects.

If renal impairment exists, even usual doses may lead to excessive accumulation of the drug and possible hepatic toxicity. For such patients, lower than usual doses are indicated and, if treatment is prolonged, Vibramycin serum level determinations may be advisable.

Vibramycin, like other tetracyclines, may form a stable calcium complex in any bone-forming tissue, although *in vitro* Vibramycin binds calcium less strongly than other tetracyclines. The use of Vibramycin during tooth development (last trimester of pregnancy, neonatal period, and early childhood) may cause discoloration of the teeth (yellow-gray-brownish). This effect may occur mostly during long-term use, but also may occur with short-treatment courses.

Increased intracranial pressure with bulging fontanelles has been observed in infants receiving tetracyclines. This effect has disappeared rapidly on cessation of therapy with no sequelae.

In certain hypersensitive individuals treated with Vibramycin, exposure to direct sunlight may precipitate a photodynamic reaction. In individuals with a history of photoallergic reactions to tetracyclines, exposure to direct sunlight should be avoided and treatment should be discontinued at first evidence of skin discomfort.

Precautions: As with any antibiotic, overgrowth of nonsusceptible organisms may occasionally occur. Constant observation of the patient is essential. If such superinfections are encountered, Vibramycin should be discontinued and replaced by appropriate therapy.

When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be utilized. In all cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months.

Adverse Reactions: Nausea, vomiting, diarrhea, vaginitis, as well as reactions of an allergic nature such as dermatitis, urticaria, and anaphylaxis may occur but are rare. Glossitis, stomatitis, proctitis, onycholysis and discoloration of the nails may rarely occur during tetracycline therapy as with other antibiotics. If severe adverse reactions, individual idiosyncrasy, or allergy occur, discontinue medication.

As with other tetracyclines, elevation of SGOT or SGPT values, or elevated BUN have been reported, the significance of which is not known at this time. Anemia, neutropenia, and eosinophilia have been reported, as with other tetracyclines.

Animal Pharmacology: As with other tetracyclines, at doses greater than those recommended for human usage, Vibramycin produces discoloration of animal thyroid glands. Careful monitoring of animals and humans has disclosed no abnormalities of thyroid function studies. Also, as with other tetracyclines, at relatively high oral doses, evidence of hepatotoxicity has been noted in dogs and signs of gastrointestinal intolerance have been seen in both dogs and monkeys.

Dosage: The usual dose of Vibramycin is 200 mg. on the first day of treatment (administered 100 mg. every 12 hours) followed by a maintenance dose of 100 mg./day. The maintenance dose may be administered as a single dose, or as 50 mg. every 12 hours. In the management of more severe infections (particularly chronic infections of the urinary tract), 100 mg. every 12 hours is recommended. The recommended dosage schedule for children weighing 100 pounds or less is 2 mg./lb. of body weight divided into two doses on the first day of treatment, followed by 1 mg./lb. of body weight given as a single daily dose or divided into tw doses, on subsequent days. For more severe infections up to 2 mg./lb. of body weight ma be used. For children over 100 lbs. the usual adult dose should be used.

Acute gonococcal anterior urethritis in males —a single dose of 300 mg. or 100 mg. b.i.d. for 2-4 days.

Acute gonococcal infections in the adult fem should be treated with doses of 100 mg. b.i.d until cure is effected.

Therapy should be continued beyond the tim that symptoms and fever have subsided. When used in streptococcal infections, thera should be continued for 10 days to prevent the development of rheumatic fever or glomerulonephritis.

If gastric irritation occurs, it is recommende that Vibramycin be given with food or milk. Studies indicate that the absorption of Vibramycin is not markedly influenced by simultaneous ingestion of food or milk.

Simultaneous administration of aluminum h droxide gel given with tetracycline antibiotic including Vibramycin has been shown to de crease absorption.

Supply: Vibramycin Hyclate (doxycycline hyclate) is available as capsules containing doxycycline hyclate equivalent to 50 mg. of doxycycline, bottles of 50, unit-dose pack of 100 (10 x 10's), and X pack of 50 (5 x 10's); capsules containing doxycycline hyclate equivalent to 100 mg. of doxycycline, bottles of 50, unit-dose pack of 100 (10 x 10 and V pack of 25 (5 x 5's).

Vibramycin Monohydrate (doxycycline mon hydrate) is available as a dry powder for ora suspension containing when reconstituted doxycycline monohydrate equivalent to 25 r of doxycycline per 5 cc. (each teaspoonful) with a pleasant-tasting raspberry flavor, 2 c bottles.

More detailed professional information available on request.

Pfizer LABORATORIES DIVISION
New York, N.Y. 10017

Vibramycin®
(doxycycline)
a semi-synthetic tetracycline

(Continued from Page 987)

Only For The Patient's Benefit

There can be no doubt that the X-ray machine is now both a necessity and a benefit in the diagnosis and treatment of the sick. Physicians would have a difficult task in performing "modern medicine" without it. Diagnostic and therapeutic effects of ionizing radiation are of definite advantage to the ill.

As with potent drugs, there is some danger in the administration of X-ray. The only circumstance under which ionizing radiation can be justifiably administered to a patient is for the patient's benefit in diagnosis or treatment of his illness.

The primary responsibility for the diagnosis and treatment of illness in this State lies with the physician. This primary responsibility is both legal and moral in character.

It appears to me that it is the responsibility of the physicians of the State to determine which patients will be X-rayed. This will always be accomplished after weighing the probable benefits of X-ray against the possible dangers. The possible dangers of radiation cannot be separated from the manner in which the radiation is delivered.

The largest factor in relatively safe delivery of radiation is the competency or proficiency of the operator of the X-ray machine. Such operators are properly referred to as "radiologic technologists." There can be no doubt that the operator should prove proficiency before he is allowed to administer ionizing radiation to the patient. This is particularly true in the case of diagnostic ionizing radiation. State certification for radiological technologists is definitely recommended, provided the physicians in the State are included in a position of responsibility in the certification process.

The Medical Association of the State of Alabama should take a position of leadership in the initiation of such a certification program. We should be mindful, however, that this program is only for the benefit of the patient and that the primary responsibility for the treatment of the patient remains vested in the physician.

—R. E. Foy, M. D.

Is Spreading Narcotics Use Triggering A Nation's End?

"Is America dying?" asks Ralph Ginzburg in the chapter heading of a book published three years ago, and he quotes everybody from Wayne Morse to Bruce Catton, from Philip Wylie to Vance Packard, from Mrs. Bonaro Overstreet to Tallulah Bankhead, to prove something or other.

Fifteen years ago, John T. Flynn, a Long Island lawyer, bylined a book titled, "The Decline of the American Republic."

And a couple of months ago, Carl O. Rice, M. D., wrote an editorial in Minnesota's Journal of Medicine captioned: "The Decay of Civilization?" This one looked at current narcotic-addiction trends and turned up historic parallels in ancient Greece and Rome and more modern China.

In the current spread of narcotics addiction, Dr. Rice sees signs of an insidious syndrome that "can be psychological and spiritual: denial of bright hopes, desecration of high ideals, defeat of noble purposes . . . It is obvious that the whole problem of opium and drugs is closely connected with the social upheavals which are now upsetting our restless world."

Dr. Rice opened his editorial with a quota-

tion from an early 20th-century medical missionary to China: "Were you to ask me the cause of China's mental, moral and physical degradation, there could be but one answer, Opium."

And had this Minnesota physician turned to a Britannica of 50 years ago he might have been startled by an even sharper parallel. The first edict prohibiting opium was issued by Emperor Yung Cheng in 1729, nearly half a century before the American Revolution. Importation was forbidden by Chinese imperial authorities in 1796. But by that time the East India Company had taken over the Indian trade, ignoring the Chinese to bring opium to a ready market.

Opium smoking penalties increased to the death penalty to no avail until Emperor Taokwang's commissioner, Lin Tsze-su, threatened hostile action against the British ships. When Lin seized and destroyed $10 million worth of opium, the British turned to smuggling. Outrages on both sides led to open war, which ended with the Treaty of Nanking in 1842. But the British had won the last battle. Sixteen years later, the Chinese government acknowledged their laws were ineffective and opium was legalized in 1858.

Meantime, however, every province in China had begun producing its own opium. It fast became the principal if not the only national stimulant. And so, when the Chinese government in the first two decades of the 20th century finally got around to the herculean task of eradicating it, the odds seemed insurmountable. Not only was opium a fixture in the national economy, it was also a national habit.

Seven years ago this month *Horizon* (A Magazine of the Arts) posed a question about LSD: "Can This Drug Enlarge Man's Mind?" It pointed out that "since earliest times man has felt impulses to rise above his everyday self and achieve either some higher insight or some release from mundane concerns," generally with drugs.

The author had himself been on trips, and he announced that "LSD is certainly one of the least toxic chemicals man has ever put inside his system. Compared with alcohol, nicotine, coffee—our three great stand-bys—it could be called almost a docile mare as against these mettlesome stallions . . ." He wants only "competent researchers" to offer themselves as voyagers to the "Gate of Ivory."

In his editorial, the Minnesota physician decides, for some reason, that "Our civilization will not decay, but let's get off our duff."

One may hope he is right. But let's not forget that marijuana is hashish, from the Arabic word "hashishin" (or, hemp eaters) from which comes the English word, assassin.

Ef-
fic-
iency

Dicarbosil®
ANTACID

Your ulcer patients and others will confirm it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

Pictorial Highlights of The 109th Annual Session

Wednesday, April 29, 1970

MASA IN MOBILE



















M (for Meetings)

1. New MASA Officers: From left: Dr. Henry Gunter Hodo, Jr., Fayette, addition to Board of Censors; Dr. Archie Edwin Thomas, Montgomery, President-Elect; Dr. Samuel Buford Word, Birmingham, President.
2. Board of Censors: Regular session, held at annual meeting in Mobile.
3. Secretary-Treasurer Reports: Dr. William Lamar Smith, Montgomery.
4. Orientation Program: Mrs. John M. Chenault of Decatur, President, Woman's Auxiliary to the American Medical Association, addressing an Orientation Session at 9:30 a.m. Thursday, April 30th.
5. Scientific Session: Dr. Claude Frazier, Chief of Allergy, Memorial Mission Hospital, Asheville, N. C., is speaking on "Allergy in Children."
6. General Session: A view from the back of the room of the business session.
7. Mobile Auxiliary Members (serving as hostesses): From left: Mrs. James C. Barrett, Mrs. Richard W. Kramer, Mrs. Byron E. Green, Jr., Mrs. Joseph E. Nelms, Mrs. N. C. Nichols.
8. Dr. C. Kermit Pitt, retiring president, Medical Association, as he presided over one of the numerous sessions of the four-day meeting.
9. International College of Surgeons: From left, seated: P. R. Tunstall, Nelson L. Brown, S. R. Terhune, Milton M. Leigh.

Pictorial Highlights of The 109th Annual Session

Thursday, April 30, 1970



A (for Activities)

1. Gaslight Party: The great fun event of the annual session, pictured in the assortment of pictures of characters and routines occupying left of page above.

2 & 3. Registration Desks.

4. Past Presidents, WAMASA: From left (seated): Mrs. Ira B. Patton, Oneonta, 1966-67; Mrs. James Gordon Daves, Cullman, 1950-51; Mrs. Gerald G. Woodruff, Anniston, 1948 49; (standing). Mrs. William James Rosser, Birmingham, 1949-50; Mrs. William Noble, Fort Payne, 1957-58; Mrs. J. C. Guin, Tuscaloosa, 1967-68; Mrs. John M. Kimmey, Elba, 1962-63; Mrs. Robert K. Wilson, Aliceville, 1968-69.

5. Class of 1910, Alabama Medical College of Mobile. From left (seated): Dr. William Blair, West Palm Beach, Fla.; Dr. Samuel S. Gaillard, Frisco City; Dr. Marion L. Shaddix, Gadsden; (standing): Dr. Ollie E. Wilson, Birmingham; Dr. Gilbert F. Douglas, Sr., Birmingham; Dr. R. C. Williams, Atlanta... Two members of this Class of 1910 missing from the picture are: Dr. W. J. Blount, Millry, and Dr. Sidney D. Armistead, Robertsdale.

6. Before ALAPAC Exhibit Booth: From left: Dr. Gerald D. Dorman, New York, president, American Medical Association; Mrs. James K. V. Willson, Mobile, chairman of ALAPAC Hostesses; Mrs. M. Vaun Adams, Mobile, co-chairman, ALAPAC Hostesses; and Mrs. Dorman.

Pictorial Highlights of The 109th Annual Session

Friday, May 1, 1970



S (for Speakers)

1. A Standing Ovation was given a New York Priest, the Rev. Father Daniel Egan, when he spoke on drug addiction before the WAMASA luncheon. He is posed here between the incoming President, Mrs. Howard C. Johnson of Sheffield, and the outgoing President, Mrs. Benjamin H. Johnson, Jr., of Bessemer.
2. ALAPAC Luncheon Speaker, Governor Brewer at microphone. To his left are Dr. Grover C. Murchison, Jr., ALAPAC Board Chairman, and Dr. Gerald D. Dorman, AMA President. To his right, Dr. C. Kermit Pitt, retiring MASA President, who introduced him... In foreground, backs to camera, are Dr. and Mrs. Benjamin H. Johnson, Jr. Mrs. Johnson is a member of ALAPAC's Board of Directors.
3. Mrs. B. H. Johnson at microphone.
4. Governor Brewer.
5. Dr. Pitt.
6. Dr. Murchison.
7. Dr. Otis R. Bowen, Speaker of the House, Indiana Legislature, with Mrs. Bowen.
8. Dr. G. Robert Bartron, President Protempore, South Dakota Senate, addressing the Awards Dinner Friday night.
9. Mayor Joe Bailey welcoming MASA and WAMASA to Mobile.
10. Dr. William T. Wright, president, Mobile Medical Society, welcoming convention.
11. Dr. Claude Frazier, Asheville, N. C., addressing the First Scientific Session on "Allergy in Children."

Pictorial Highlights of The 109th Annual Session

Saturday, May 2, 1970



A (for Awards)

1. Dr. and Mrs. C. Kermit Pitt at Awards Dinner Speakers' Table with the wife of the principal speaker, Dr. G. Robert Bartron of South Dakota.
2. Dr. Hugh E. Gray receiving a Past President's Plaque from Dr. John M. Chenault.
3, 5 & 6. Mrs. G. L. Wideman, WAMASA President-Elect, Birmingham; Mrs. George Hansberry, Decatur; Mrs. William L. Smith, Montgomery, in that order, receiving special awards for skits in Gaslight Party.
4. Dr. C. L. Salter, recipient of Robins Award, with Mrs. Salter.
7. Fred W. Abt receiving William Crawford Gorgas Award from Dr. E. W. Stevenson, Birmingham.
9. William Henry Sanders Award recipient, Dr. Harold Klingler.
8, 10 & 11. Miss Anita Smith, Birmingham News; Don Chapin, Huntsville Times; and Dave Williams, WFPA Radio, Fort Payne, in that order, receiving Douglas L. Cannon Medical Reporter Award. In foreground of Picture No. 11 is Dr. Ira B. Patton, Oneonta, who presided over the Awards dinner as Chairman, Committee on Public Relations.



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

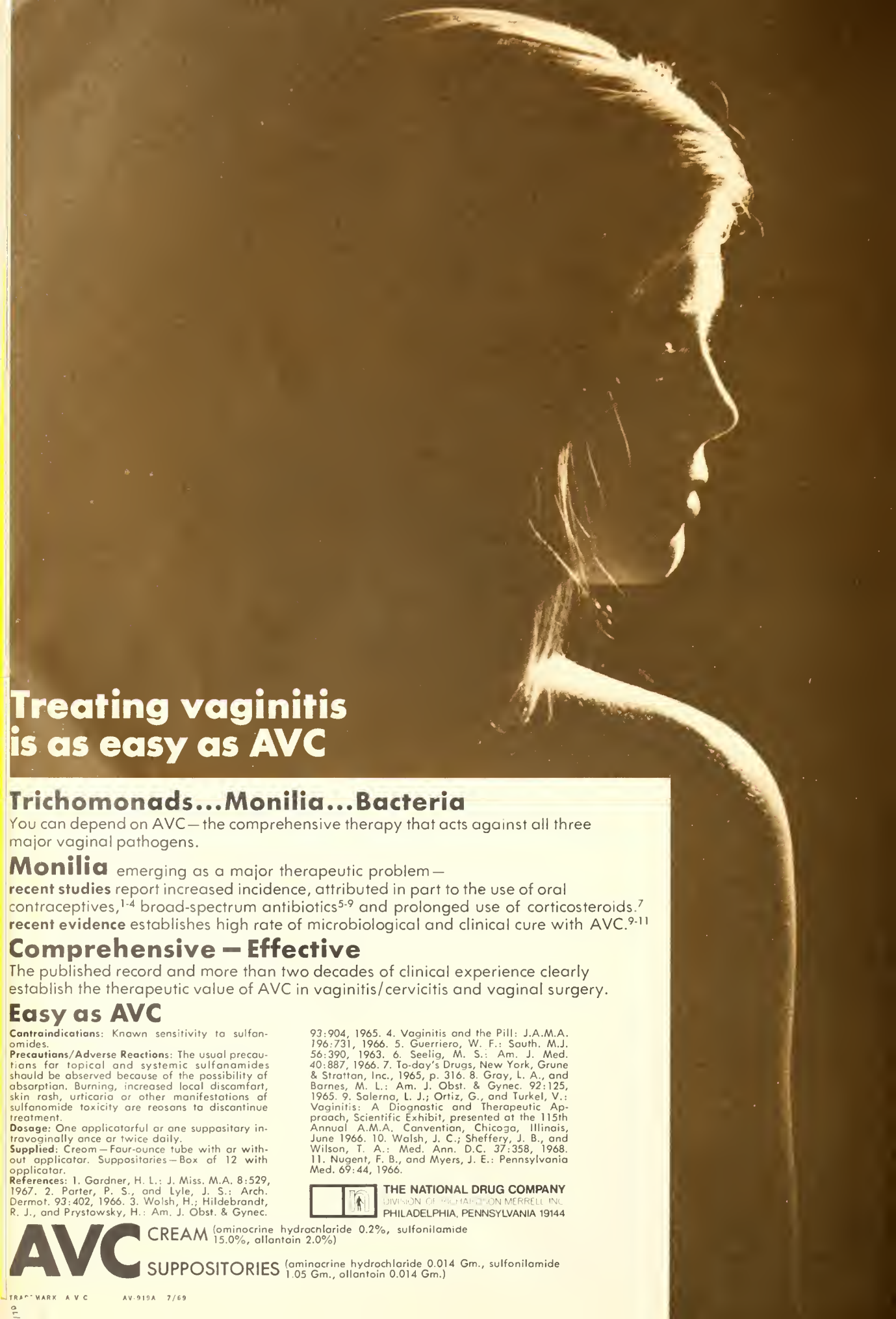
One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps



Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive — Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfanomides.
Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfanamides should be observed because of the possibility of absorptian. Burning, increased local discamfart, skin rash, urticaria or other manifestations af sulfanomide toxicity are reosans ta discantinue treatment.
Dosage: One applicatarful ar ane suppasitary intravaginally ance ar twice daily.
Supplied: Creom—Faur-ounce tube with ar without applicatar. Suppositaries—Box af 12 with applicatar.
References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Parter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: Sauth. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Strattan, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerna, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diognastic and Therapeutic Appraach, Scientific Exhibit, presented at the 115th Annual A.M.A. Canventian, Chicaga, Illinais, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

AVC CREAM (ominocrine hydrachlaride 0.2%, sulfonilamide 15.0%, allantain 2.0%)

AVC SUPPOSITORIES (aminacrine hydrochlaride 0.014 Gm., sulfonilamide 1.05 Gm., allantoin 0.014 Gm.)

TRADEMARK A V C AV-919A 7/69

Legal Page:

The Doctrine Of Res Ipsa Loquitur

By J. Jerry Wood, J. D.

The Latin phrase "res ipsa loquitur" literally means "the thing speaks for itself." At the law, *res ipsa loquitur* raises a rebuttable presumption that the defendant was negligent, which arises upon proof that the instrumentality causing the injury was in the defendant's exclusive control and that the accident was one which ordinarily does not happen in the absence of negligence.[1]

In malpractice cases when res ipsa loquitur is discussed, it usually indicates medical errors upon which any layman is competent to make judgments and conclude from common experience that whatever injuries have occurred do not happen if proper skill and care have been utilized. A good example of the use of the doctrine of res ipsa loquitur is a case in which a foreign object is left in a patient's body after an operation. Because of the alleged "conspiracy of silence" among members of the medical profession, the courts have historically allowed a plaintiff to come to trial without expert witnesses in res ipsa situations.

It is generally recognized that the doctrine of res ipsa loquitur arises only in those cases where the following three elements are present.

(1) The injury must be of a kind which ordinarily would not occur in the absence of someone's negligence.

(2) It must be caused by an agency or instrumentality within the exclusive control of the defendant.

(3) It must not have been due to any voluntary action or contribution on the part of the plaintiff.

The facts in the case must be so clear that a layman can say as a matter of common knowledge that the results of the examination, treatment or surgery, are not results that would ordinarily occur in the absence of negligence on the part of the treating physician.

In addition to foreign objects being left in the patient's body, res ipsa has been applied when there are injuries to a part of the body not under treatment or operation, while the patient was unconscious; X-ray burns in the use of X-rays for diagnosis; injuries resulting from the use of mechanical devices; mistakes in the administration of solutions and severe physical injury to mental patients.

Generally the doctrine does not raise a presumption of negligence requiring a verdict for the patient; rather, it raises a permissible inference which allows the jury to find the physician negligent *without proof* of a specific act of negligence or testimony of other physicians.

Originally, the doctrine of res ipsa loquitur was logically and justly applied. The judicial authorities in early cases treated res ipsa as "a doctrine of circumstantial evidence." However, with the judicial extentions and expansions of the doctrine, we have come very close to liability without fault or absolute liability.

Physicians should not be placed in the position of making patient care judgments which may be colored by legal considerations which may adversely affect the patient's welfare.

Several state legislatures, including California, have considered and will consider legislation which will limit the application of the doctrine of res ipsa loquitur.

In the next session of the Alabama Legis-

1. Blacks Law Dictionary, Fourth Edition, 1951.

lature a bill will be introduced to eliminate the res ipsa loquitur doctrine except in foreign body cases and when surgery is on the wrong part of the patient's body.

The following cases all illustrate the application of the doctrine of res ipsa loquitur.

Davis v. Trobough,
363 P. 2d 727 (Mont., 1961)

A surgeon who performed a hysterectomy was not legally liable for damages merely because the patient developed a vesical-vaginal fistula after the operation. A verdict in favor of the surgeon and a non-suit in favor of his assistant were affirmed by an intermediate appellate court in California.

The appellate court said that the application of the doctrine of *res ipsa loquitur* was properly denied in this case. It held that it was not a matter of common knowledge among laymen or physicians or both that a vesical-vaginal fistula would not occur after a hysterectomy in the absence of negligence. The testimony of many medical witnesses indicated that such fistulas did occur in a small percentage of cases even though reasonable skill and care were exercised.

Demchuk v. Bralow,
170 A. 2d 868 (Pa., 1961)

A mentally disturbed patient who had voluntarily entered a sanitarium for treatment fractured his ankle in climbing over a wall while left unattended. In claiming damages, the patient said that he had no recollection of what had occurred. The jury brought in a verdict for the sanitarium and a judgment was entered thereon.

On appeal the judgment was affirmed. The intermediate appellate court held that instructions to the jury were not in error. The jury was properly instructed that the doctrine of *res ipsa loquitur,* under which the patient could recover without proof of negligence, would apply if the jury believed that the patient was not accountable for his actions because of his mental condition. The court said that there was no reason for distinguishing this situation from that of an unconscious patient. In these circumstances, however, another instruction that the mere fact that an accident occurred did not establish negligence was not inconsistent, since the application of the doctrine depended upon a determination of a question of fact by the jury.

The jury was also properly instructed that the sanitarium was required to exercise such reasonable care as the known condition of the patient required. The patient was not entitled to an instruction requiring the highest degree of care. It was properly instructed that the sanitarium was required to exercise that degree of care used by sanitariums generally in the community. The patient was not entitled to instructions on a special standard of care for sanitariums specializing in the care of mentally disturbed patients.

Morgensen v. Hicks, et al.,
Supreme Court of Iowa, 114-50347 (1961)

Damages were recovered, under the Federal Tort Claims Act, by a serviceman and his wife for injuries suffered by the wife because of the transfusion of incompatible blood. The wife recovered $40,000 for pain, suffering, mental anguish, loss of physical ability to perform household tasks, permanent injury to her kidneys, and permanent rheumatoid arthritis. The serviceman recovered $10,000 for loss of the services and companionship of his wife.

The wife was given a transfusion of 1,000 cc. of blood in connection with a hysterectomy performed at an Army hospital. Her blood had previously been typed as Group O positive. In typing her blood for the transfusion, a hospital technician determined that it was Group B positive. She was transfused with Group B positive blood and developed a hemolitic reaction. Her blood was immediately retyped and was determined to be Group O positive.

Without deciding whether the doctrine of *res ipsa loquitur* (under which negligence

(Continued on Page 1002)



relieved with MEASURIN® q. 8h. dosage

Double-strength Measurin timed-release aspirin offers a new kind of control for your arthritic patients. Each 10-grain tablet has over 6,000 microscopic reservoirs that release aspirin at a controlled rate—some right away and some later on. This means—fast relief, followed by long lasting relief. Throughout the day, Measurin gives your patients freedom from a 4-hour dosage schedule. Measurin can help your patients get a good night's sleep, uninterrupted by the need for an extra dose of aspirin. And, taken at bedtime, it also helps ease morning joint discomfort and stiffness.

For Professional Samples write:
Breon Laboratories Inc.
Sample Fulfillment Division
P.O. Box 141
Fairview, N.J. 07022

BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016
Subsidiary of Sterling Drug Inc.

MEASURIN®
TIMED-RELEASE ASPIRIN

ECONOMICAL • EFFECTIVE • LONG LASTING PAIN RELIEF
Dosage: 2 tablets followed by 1 or 2 tablets every 8 hours as required, not to exceed 6 tablets in 24 hours. For maximum nighttime pain relief and to help relieve early morning stiffness, 2 tablets at bedtime.
Available: Bottles of 12, 36 and 60 tablets.

(Continued from Page 1000)

can be presumed from the occurrence of an injury in certain circumstances) was applicable in this case, the court held that there was sufficient evidence to establish negligence by the hospital personnel in typing the wife's blood and that this negligence was the proximate cause of her injury.

Under the law of Oklahoma, where the hospital was located, the serviceman was not entitled to recover for his mental anguish. That element of damages is not allowed in Oklahoma unless the wife dies. The court fixed the attorney's fees at 20 percent of the total amount recovered, to be paid out of, but not in addition to, the amount of the judgment.

DeMartini v. Alexander Sanitarium, Inc.,
13 Cal. Rptr. 564 (Calif., 1961)

The Supreme Court of Iowa has held that *res ipsa loquitur* does not apply when a patient has an allergic reaction to a local anesthetic.

In the particular case under consideration by the court, the plaintiff, 28 years old, had experienced some bleeding when he urinated. Accordingly, it was decided that he should undergo a cystoscopic examination. In order to eliminate any pain or discomfort, it was necessary to anesthetize his penis. An anesthetist injected from 1 to 1½ c.c.'s of pyribensamine when the plaintiff experienced a sharp burning pain. At the same time the skin around the urethra became white. No further injection was made and the examination was abandoned. The plaintiff was then treated for an allergic reaction to the anesthetic. The plaintiff was away from work for two weeks. He experienced pain and some difficulty in urinating.

The plaintiff's suit was based on the doctrine of *res ipsa loquitur*. The jury returned a verdict of $8,000. On appeal the Supreme Court of Iowa reversed this judgment.

The court pointed out that one of the essential elements of *res ipsa loquitur* is that "the instrumentalities causing the injury must have been under the exclusive control of defendants." The court ruled: "The doctor was not in full control of the instrumentalities involved. He controlled the surgical instruments and the medicine, but he had no control over the condition and reactions of his patient. The allergic reaction of plaintiff in the instant case was an element beyond his control."

Medicine In Roman Empire

The most famous doctor in Rome was Galen. He was also the cockiest. He had all the answers, and went around looking for questions. Galen flatly stated that he cured everyone, though there were those who hinted he may have swept a few patients under the rug. Herbs were his favorite cure. He had an herb for every disease, and is even rumored to have fixed a broken leg by using an asparagus stalk as a splint. In a work called *De Simplicibus* he made everything sound simple, refusing even to admit that there was such a thing as a compound fracture.

He had some offbeat ideas about blood, which he thought so full of Natural Spirit, Vital Spirit, and Animal Spirit that there was no room for red and white corpuscles. Nevertheless, everyone took him as the final authority. If there was any question about a medical matter, people said with a shrug, "Ask Galen." Had he lived 1800 years later, he could have written a medical column and syndicated it in hundreds of newspapers.

Galen made a big point of numerology, emphasizing the importance of five senses, four elements, four humors, two sexes, one head, etc. Everyone agrees with him about the importance of two sexes and shudders at the thought of there being even one more or one fewer.

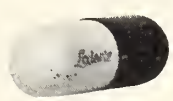
Richard Armour: *It All Started With Hippocrates,* 1966.

Doctor, after all we've been through together...

abscess
acne
amebiasis
anthrax
bacillary dysentery
bartonellosis
bronchitis
bronchopulmonary infection
brucellosis
chancroid
diphtheria
endocarditis
genitourinary infections
gonorrhea
granuloma inguinale
listeriosis
lymphogranuloma
mixed bacterial infection
osteomyelitis
otitis
pertussis
pharyngitis
pneumonia
psittacosis
pyelonephritis
Rocky Mountain spotted fever
scarlet fever
septicemias
sinusitis
soft tissue infection
tonsillitis
tularemia
typhus fever
urethritis

...don't you think it's time we were on a first-name basis?

call me "Achro® V"



Every pharmacist knows ACHRO® V stands for ACHROMYCIN® V

ıtraindications: Hypersensitivity to acycline.
rning: In renal impairment, since r toxicity is possible, lower doses indicated; during prolonged therapy sider serum level determinations. otodynamic reaction to sunlight may ur in hypersensitive persons. otosensitive individuals should id exposure; discontinue treatment in discomfort occurs.
cautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).
Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, cosinophilia. *Liver*—cholestasis at high dosage. Upon adverse reaction, stop medication and treat appropriately.

Achromycin® V
Tetracycline

Lederle LEDERLE LABORATORIES • A Division of American Cyanamid Company, Pearl River, New York 10965

484-9



The Month in Washington

From the Washington Office
American Medical Association

The Nixon Administration proposed that prepaid, closed-panel group practice health care be authorized under both medicare and medicaid.

The American Medical Association recommended to the House Ways and Means Committee a new medicaid plan utilizing existing private health insurance mechanisms to replace the present program of health care assistance for the medically indigent.

Robert H. Finch, secretary of Health, Education and Welfare, said Congress would be asked to approve legislation authorizing "health maintenance contracts guaranteeing health services for the elderly and the poor at a single fixed annual rate for each person served."

"In the case of medicare," Finch said, "the patient will be entitled under such a contract to all of the usual medicare services plus preventive services. The contract price will be negotiated in advance at an amount less than the Social Security Administration presently pays for conventional medicare benefits in the locality.

"Similarly under medicaid we are seeking authority for the states to offer to the poor the option of securing services under such health maintenance contracts. We propose to work with the individual states toward the modification of their present programs in this regard and to encourage their use of the experimental authority previously mentioned for the testing of a variety of different contractual arrangements.

"The cornerstone of this new option in federal health purchasing will be the opportunity for consumers to choose between alternatives. The ultimate goal will be to give every beneficiary of these programs a choice between obtaining services from a health maintenance organization or arranging for them in the usual way from individual doctors and hospitals. He will have the choice of withdrawing from enrollment in a health maintenance organization if he finds the service unsatisfactory. The government will have the choice of entering into arrangements with individual health maintenance organizations, subject to special standards including assurance that every contractor will serve persons of high medical risk as well as the healthy."

Earlier, HEW Under Secretary John G. Veneman told the House committee that it was planned to call the new approach under medicare Part C—to provide all services covered under Parts A and B "plus preventive services." He estimated a saving of about $15 per person, but some committee members were skeptical that more services could be provided at less cost.

Both Finch and Veneman made clear that one of the main objectives is a fundamental change in the nation's system of health care delivery. They said states would ask to repeal existing laws restricting prepaid group practice. They said that future federal medicaid funds might be made contingent on states eliminating "legal barriers to all forms of health delivery organizations."

"Let me conclude by saying that our broad objective is to frame an effective and reasonable approach to meet the health needs of the American people," Veneman said. "Obviously the federal government by itself cannot redirect the total health delivery system. We can, however, do our best to make sure that the vast expenditures of the federal

government in the health care industry are used in a way that will contribute to the evolution of an improved, more effective, more economical system to deliver health care to our people. To the extent we are successful, we will be delivering the maximum benefit from the public funds entrusted to us. But what is equally important, we will be providing valuable support for improvement of the total health care system, public and private. In that way, we will be helping to improve the delivery of health services for all the American people."

Dr. Russell B. Roth, speaker of the AMA House of Delegates, told the House committee that medicaid "has demonstrated some weaknesses which badly need correction."

A new program, he said, should: "provide the Congress with a basis for reasonable predictable costs; ease the burden on the states; assure total implementation; and while maintaining a level of quality, insure that the costs of the program remain within the range of acceptability."

The program recommended by the AMA had these features:

1. Each eligible person (or family) would receive a certificate to be redeemed by a qualified health insurance company offering a health insurance policy or contract of certain basic health benefits such as hospitalization, medical care, preventive care, and diagnostic and outpatient care.

2. The premium cost for such policy or contract would be assumed by the federal government from its general revenue fund.

3. The states, freed from the expense of financing the basic costs of health care for their indigent and medically indigent residents, could provide supplementary benefits. These might include, for example, skilled nursing home care and dental services.

4. The determination that an insurance policy or contract, and the company offering same, are "qualified" would be made by a state agency which customarily has that authority. However, changes in the scope of benefits, and guidelines or standards to be used by the insurance departments in judging the company and the plan it offers, would be established by a national board appointed by the President.

5. All individuals and families below a certain level of income would be eligible to participate. A simple determination of eligibility could be made by the appropriate federal agency on the basis of income, or an even more refined criterion could be used such as tax liability. The program could require marginal needy families to participate in the expense of the premium charge by paying a small part of it, varying such participation in direct proportion to this tax liability.

6. For the lower income family there would be no deductibles and no co-insurance features.

7. To insure a high level of quality and to prevent cost escalation, the program would provide for a system of "peer review," organized and conducted in a manner to assure its success.

As to those services and charges which are within the purview of the medical profession, appropriate medical societies would be given the task of establishing a peer review mechanism that would, among other things, review individual charges and services wherever performed; review hospital and skilled nursing home admissions as to their medical necessity, and stays in hospitals and skilled nursing homes as to their continued medical necessity; and review the need for the professional services provided in the institution.

In the case of fraud or other clear intentional and gross misconduct, the peer review committee would be expected to bring charges before the appropriate licensing body.

To assist peer review committees in be-

coming established and in their operation, the program should provide for federal participation in the cost incurred in developing the program and its operation. To assure participation by members of the profession, those who serve on peer review committees should be held harmless from any actions or claims based on their decisions as to the necessity or quality of the services provided, or the reasonableness of the charge.

In the event that a peer review committee is not established by the appropriate medical society within a reasonable time, or although established is not functioning, the Secretary of Health, Education and Welfare in consultation with the medical society, would be empowered to appoint a committee to so act.

* * *

The American Medical Association supports the Nixon Administration's air pollution control bill (S. 3466) which would give the Department of Health, Education and Welfare power to set air quality standards for the nation.

The legislation also would provide for intensified research in air pollution and for tough enforcement procedures on the national air purity standards.

The AMA also supports accompanying legislation providing for expanded research on ways to cut auto exhaust pollution and for pollution control standards for watercraft and airplanes.

Dr. James M. Blake, a member of the AMA's Council on Legislation, told the Senate Subcommittee on Air and Water Pollution:

"For too long we have taken for granted the atmosphere, one of our natural resources; it is time now to look upon this resource as one on which the survival of man depends . . .

"In recent years, the country has awakened to the need to control air pollution. Yet, more and more, our air becomes polluted and hazards to health increase. We must take stronger action to reverse this direction—stronger action than we have taken in the past . . .

"It is imperative, that all elements of our society join to overcome the increasing pollution of our atmosphere. Measures which a few years ago were deemed adequate to meet the needs simply have not achieved the desired goals. New steps must be taken if we are to make any substantial headway in alleviating the problem. Accordingly, we believe that it is now necessary to provide for additional pollution controls and to make the essential financial commitment . . ."

* * *

States must report to the Internal Revenue Service each year on total payments to providers of medicaid services under new regulations issued by the Department of Health, Education and Welfare.

Each year, states will file Internal Revenue Service Forms 1096 and 1099 giving amounts paid to physicians, dentists, pharmacists, opticians, nursing homes, hospitals and other individuals and institutions that provide service to medicaid patients.

States will be required to identify each individual provider of service by social security number, and partnerships and corporations by an employer identification number.

States also must establish procedures for verifying with recipients whether services billed by providers were actually received. Such verification may be made by spot checking.

* * *

President Nixon approved a $65 million increase in the Veterans Administration medical care budget mainly to improve services for wounded Vietnam war veterans.

An increase of $50 million was authorized in the VA's medical budget for fiscal 1971 and $15 million for the remainder of this fiscal year. Nixon acted after reviewing a study by Veterans Administrator Donald E. Johnson of the scope of the veterans medical care program and the increasing diffi-

(Continued on Page 1009)

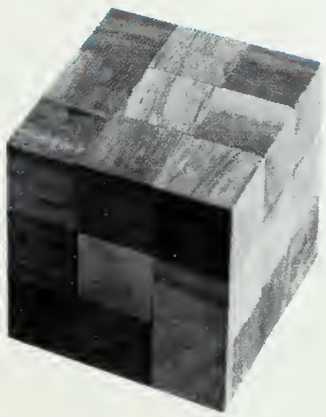
IN G.U. THERAPY

Does not create problems...



SOLVES THEM

WITH FIRST DOSE PAIN RELIEF



Urised is a problem solver through its time tested record of minimal side effects. Unlike newer antibiotics or sulfonamides, Urised does not create problems. It brings patient comfort with first dose pain relief. For over 50 years, Urised has created physician and patient confidence by providing effective therapy when needed.

Clinically effective for G.U. Therapy[1-5]

URISED®

For G.U. Frequency – Urgency – Burning

- **CYSTITIS**
- **PYELITIS**
- **TRIGONITIS**
- **URETHRITIS**

Each blue-coated tablet contains active:

Atropine Sulfate	0.03 mg.	Methylene Blue	5.4 mg.
Hyoscyamine	0.03 mg.	Phenyl Salicylate	18.1 mg.
Methenamine	40.8 mg.	Benzoic Acid	4.5 mg.

Caution: Federal law prohibits dispensing without a prescription.

Action and Uses: Urised is effective in cystitis, pyelitis, trigonitis in pregnancy, urethritis, and other urinary tract infections where the invading organisms, such as E. coli, S. aureus and albus, are susceptible to methenamine and methylene blue in an acid medium.

URISED also is useful as a prophylactic measure prior to urinary tract instrumentation or operation. In acute fulminating infections, URISED may be used for symptomatic relief while awaiting specific laboratory diagnosis. May be combined with specific therapy where indicated.

Effects: Rapid relief of pain, relaxation of smooth muscle spasm through parasympatholytic action of atropine and hyoscyamine; pus cell content decreased.

Administration and Dosage:

Adults: Two tablets, orally, four times per day, followed by liberal fluid intake.

Children: One-half the adult dose.

Acute cases: Initially two tablets every hour for three doses, followed by the recommended daily administration.

Precautions: Administer with caution to persons with known idiosyncrasy to atropine and cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

Side Effects: Neither irritation nor untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occurs, decrease dosage. If rapid pulse, dizziness or blurring of vision occurs, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

Contraindications: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

How Supplied: Bottles of 100, 500 and 1,000 tablets.

References: (1) Sands, R. X.: New York St. J. Med. 61:2598-2602, 1961; (2) Renner, M. J., et al.: Hosp. Topics 39:71-73, 1961; (3) Haas, Jr., J., and Kay, L. L.: Southwest. Med. 42:30-32, 1961; (4) Marshall, W.: Clin. Med. 7:499-502, 1960; (5) Strauss, B.: Clin. Med. 4:307-310, 1957.

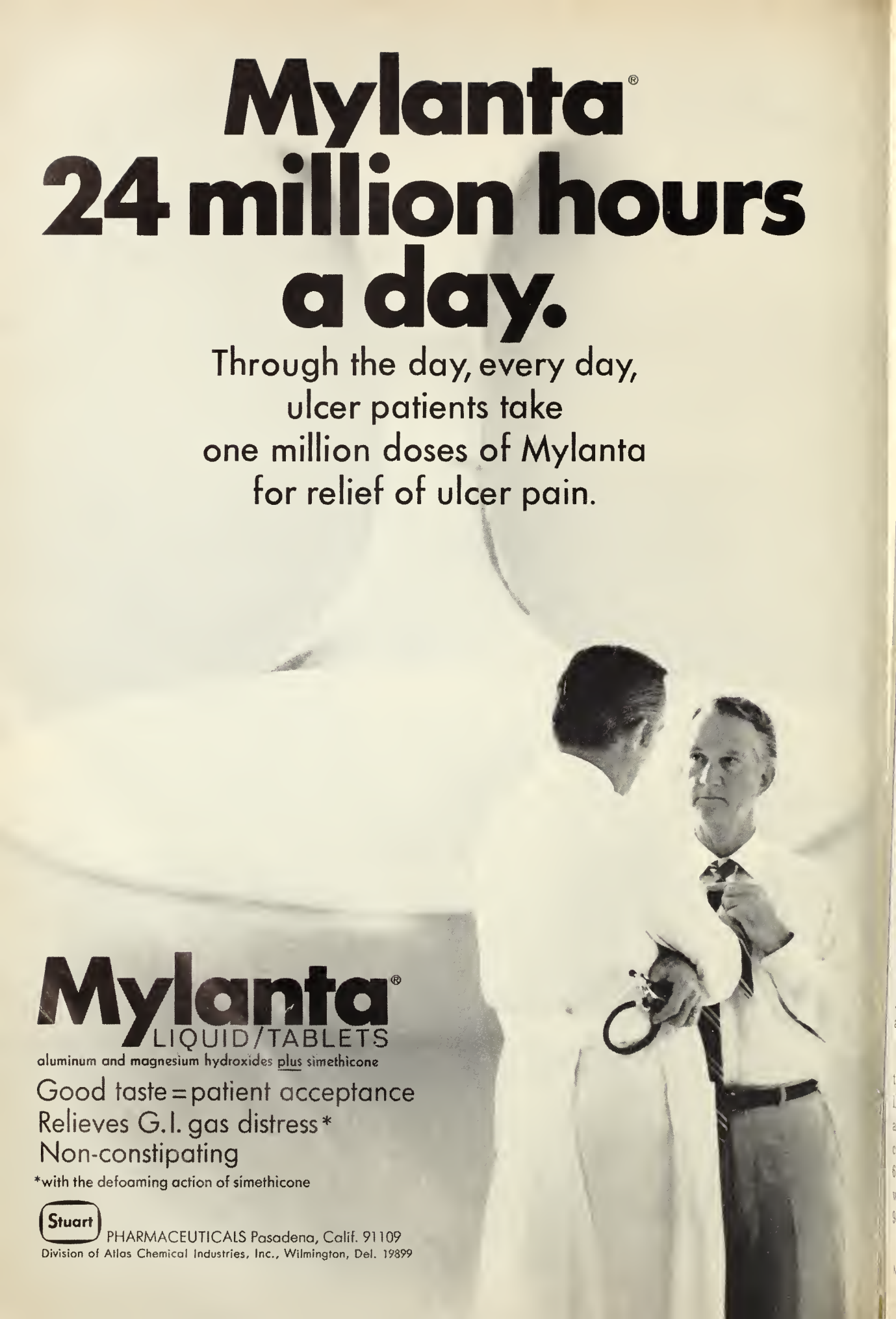
CONAL Manufacturers of Uriceutical® Specialties

Pharmaceuticals, Inc.
Chicago, Illinois 60640

MJ-GP-1

Mylanta®
24 million hours a day.

Through the day, every day,
ulcer patients take
one million doses of Mylanta
for relief of ulcer pain.



Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides plus simethicone

Good taste = patient acceptance
Relieves G.I. gas distress*
Non-constipating

*with the defoaming action of simethicone

Stuart PHARMACEUTICALS Pasadena, Calif. 91109
Division of Atlas Chemical Industries, Inc., Wilmington, Del. 19899

(Continued from Page 1006)

culties it has faced in providing hospital and clinical care.

"To those who have been injured in the service of the United States we owe a special obligation," Nixon said. "I am determined that no American serviceman returning with injuries from Vietnam will fail to receive the immediate and total medical care he requires."

The $15 million supplemental appropriation would be spent in April, May and June to clear up the excessive backlog of Vietnam veterans dental claims and to improve the staffing of specialized medical programs, especially the spinal cord injury centers and coronary intensive care units.

The additional funds also would be used to carry out plans for taking hemodialysis units into the homes of veterans suffering from serious kidney ailments and to help meet increased costs of needed drugs and medicines.

The VA's budget request already submitted to Congress for the 1971 fiscal year beginning in July totals $1.54 billion.

The new request for $50 million will bring the budget for fiscal 1971 to $210 million more than the approved appropriation for fiscal 1970.

Doctors' Age Expectancy Up

Obituaries for six doctors appear in the March, 1970 issue of *Missouri Medicine*. The youngest of the six was 48, the oldest 85, and the average age 69 years, four months.

At the same time, a look at the Dade County Medical Association's *Bulletin*, Miami, lists three physicians' obituaries, with an average age of 70 years, eight months; Wisconsin, with seven, is lowest in the averages, 67 years even, while Oklahoma is highest, with five doctors, ranging in age from 56 to 94, and an average of 75 years, three months.

Computer As Boon To Medicine

During the past several months 1,000 persons have received two hour comprehensive computerized health examinations at Swedish Convenant Hospital, 5145 N. California Ave.

Multiphasic testing is one of the newest developments in the health field, said James R. Nelson, director of development. This system gives the doctor a complete profile of the physical well being of the patient, he said.

Conducted in private examination rooms at the request of a doctor, testing is administered by technicians who employ electronic equipment and computerization.

Data derived from the tests is processed by computers which are programed to make comparisons with norms for significant factors. The computer relates any abnormality, in addition to making physical comparisions by age groups, sex, cultural background, locality of residence, and body build to derive any significant patterns.

Nelson said the computer does not take the place of the doctor but it does compile complete data for the doctor to evaluate.

The computer also is programed to tie nonrelated information with the physical data to lead the doctor to the proper diagnosis.

—Chicago Tribune

Work is something that when we have it we wish we didn't; when we don't have it we wish we did; and the object of most of it is to be able not to do any some day.

—Phenix Flame

It's good to have money and the things that money can buy, but it's good, too, to check up once in a while and make sure that you haven't lost the things that money can't buy.

—George Lorimer

Now available for your prescribing needs



Cordran® Tape

Flurandrenolide Tape (4 mcg. per sq. cm.)

Additional information available upon request • Eli Lilly and Company, Indianapolis, Indiana 46206

000108

Lilly

THE JOURNAL
of
THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA
Published Under the Auspices of the Board of Censors

Volume 39 May, 1970 No. 11

The Psychology Of The Tuberculous Patient

Verna Wool, Ph. D.

Montgomery, Alabama

Interest in the personality or psychology of the tuberculous has existed from the earliest times. Few diseases have played such an important part in medico-psychological inquiry. For many years tuberculosis was the chief cause of death. It has lost its position as the "captain of death" but continues to remain a disease of great medical interest. All experts agree that the disease has psychological aspects, that pulmonary tuberculosis is more than a disease of the lungs. Burhoe summarized this in her statement: "Tuberculosis cannot be successfully treated as a medical problem alone for its social implications are too insistent to be disregarded. . . . The discovery and treatment of the social malady are essential to recovery." Sir William Osler warned physicians that the state of the tuberculous depended more on what was in his head than what was in his chest.

The literature on the psychology of the tuberculous is still filled with more fantasy, folklore, and unsubstantiated hypotheses than science. There is considerable difference of opinion. Dr. Leslie Luehrs stated that the basic personality dynamics of the tuberculous are the result of drives of equal strengths toward aggression and passivity, toward living and dying, toward immature dependence and mature independence. As a result of these equal drives there are extreme ambivalent shiftings. Dr. Dunbar, in writing on the psychosomatic nature of tuberculosis, suggested that the patient with tuberculosis is, to use a phrase from Keats, "half in love with death." Wittkower advanced the idea that the outstanding premorbid feature is an inordinate need for affection. He suggested that persons who develop tuberculosis have an inability to deal with aggressive impulses and are apt to turn these impulses against themselves with the tuberculosis an outcome of their self-destructive trends. The conclusion to be drawn from a review of the literature is that there is no unique tuberculous personality but there is, instead, a wide variety of disturbed behavior.

Recent studies do substantiate the influence of an individual's attitudes or personality traits upon the course of his illness. It has been stated that "Sometimes it may be safer to assess the patient's prognosis on the basis of his personality and his emotional conflicts than on the basis of the shadow of his film." Some studies have found that inhibited hostility among tuberculous patients exerts an unfavorable influence, whereas the overt expression of hostility has

The following articles were presented at the Annual State Tuberculosis Meeting on February 5-6, 1970 in Montgomery, Alabama.

a favorable influence on the course of illness. The "good" patient is submissive, but has a long clinical course and recovers slowly. Contrariwise, the "bad" patient is characterized as aggressive, bold, defiant, often has a driving desire to recover and does so more quickly. In an interesting study of the relationship of adrenocortical functions and tuberculosis, Clark, Zahn and Holmes have indicated that changes in seventeen-ketosteroid excretion induced by stress correlates significantly with the course of tuberculosis. They report two cases of depressed patients with underactive adrenals who were not improving under the customary kemo-therapy. After being subjected to stressful hospital experiences which made them unduly angry or fearful, their adrenal output soared back to normal and, their recovery picked up.

A careful study by George Calden revealed a relationship between personality factors and rate of recovery. Based on test results on the Minnesota Multi phasic Personality Inventory, fast improvers obtained significantly higher scores on the Manic scale and lower scores on the hysteria, depression, and schizophrenic scales. The results suggest that patients who are most energetic and enthusiastic in spirit, most confident and outgoing are more likely to show faster improvement. In contrast patients who are more hypochondriacal, depressed, introverted and socially conforming are likely to be in the slow improvement group. The patient's attitudes as expressed on a sentence completion form also indicated that patients who were more optimistic in outlook also showed faster recovery. Patients who are diagnosed by psychiatrists as showing depressed or schizoid symptoms are more likely to improve slower, whereas patients revealing overt aggressive tendencies are more likely to be in the fast improvement group. In other words, patients who are preoccupied with their own physical and mental problems, who are quiet, conforming and withdrawn, and who constitute our "best" bedresters—these individuals seem to heal slower. On the other hand, those patients who are more outspoken, who have more drive and the will to live, who more readily reveal their hostile feelings and who do not permit themselves to sink into a state of docile passivity—these patients appear to show the most rapid improvement. The results of this particular study suggest the need, either through direct biochemical measures or through the prudent use of placebos, and particularly through the doctor-patient relationship, of building up the patient's confidence in himself and his recovery, of brightening his spirits and permitting him an outlet for his pent up emotions. These measures may serve as important allies of kemotherapy and surgery in facilitating recovery from tuberculosis.

The time has long passed when the riddle of the etiology of pulmonary tuberculosis seemed to be solved by the discovery of the tubercle bacillus and when the treatment of tuberculous patients was solely concentrated on the ravages which it causes in the pulmonary tissue. True enough, there cannot be tuberculosis without the tubercle bacillus, but it has been realized that there are many additional factors, including the psychological and the social factors, which determine the time of the onset of the manifest illness and which, for better or worse, influence the course of the illness.

In this discussion we shall confine ourselves to the personality of the tuberculous individuals in relation to the natural history of their disease. Two approaches have been used, namely, the psychosocial approach and the psychodynamic approach.

As for the *Psychosocial approach:* Cultural conflict has been found to contribute significantly to the natural history of tuberculosis. Striking features in the breakdown of the tuberculous population studied are the predominance of males, the high rate of first and second generation Americans, the frequency of broken homes in childhood, and the high rate of broken marriages, of resi-

dential mobility, of occupational transiency, and of consistent poor health.

Ecological studies revealed high rates of tuberculosis in a skid-row population and low rates in a well-to-do population. A study in Seattle concluded, "These patients, when compared with the cultural norms, were in many ways marginal people at the time of onset of tuberculosis. They started life with an unfavorable social status and grew up in an environment that was for them crippling. They were, in essence, strangers attempting to find a place for themselves in the contemporary American scene. As perceived by the individuals with tuberculosis, the poorly understood world in which they lived was a source of perennial danger, and the threat of being "walled off" and rendered "helpless" was always imminent. The nature of their attitudes and life experiences made it unusually difficult for them to decide what was expected of themselves. As a consequence, their attempts at adjustment were characterized by unrealistic striving, which was not only unrewarding but also productive of cumulative conflict, anxiety and depression.

Now, the *Psychodynamic approach:* As already pointed out, no uniform personality type covering all sufferers from tuberculosis could be delineated. Yet the frequency of certain personality features and a fairly constant psychodynamic pattern long antedating the onset of the illness have been reported.

Investigations have shown with some consistency that an inordinate need for affection is an outstanding feature of the premorbid personality of the tuberculous patient. This need for affection may be openly expressed, thinly disguised, well-concealed or flatly denied. Coupled with it are conflicts over dependency. At one end of the scale are individuals who adopt a receptive, parasitic, or leech-like acquisitive attitude toward members of their family, if not to the world in general. At the other end are individuals who, by ostentatious insistence on independence, reveal their inability to recognize or to admit their need for dependence. Between these two extremes lies the whole gamut of defenses against admission of need for affection and dependence. A well-defined in-between group is one made up of rebellious individuals whose aggressive and sometimes antisocial behavior bears the characteristics of a defensive measure. Another group consists of individuals who usually fail to make use of acting out as a character defense—conflict-harassed individuals. Accordingly, the patients were classed as overly insecure, rebellious, self-driving and conflict-harassed types.

Regardless of whether one uses the psychosocial or psychodynamic approach to explain the disease, there is agreement that emotionally disturbing events frequently precede the onset of the illness.

Holmes plotted, in a group of patients, the occurrence of stressful events for a decade preceding the onset of the illness and compared their frequency with that of a group of individuals free from tuberculosis. They found that (1) in the last few years preceding the illness the patients had suffered a much greater number of difficult and potentially distressing events and situations. (2) They were people who were less stable, less able to handle difficulties comfortably, than those who remain well and (3) they did not recognize or could not admit this personality defect.

Most tuberculosis specialists, are familiar with the type of patient who, despite all efforts on the part of the physician, steadily goes downhill and who, on exploration, is found to have no will to live or, more precisely, in a state of severe depression, quite consciously wishing to die. Beyond this, psychiatric and psychoanalytic observations have indicated that tuberculous patients in the deep layers of their minds, deflect aggressive impulses from objects in the external world to their own selves or to introjected objects.

Some experts have suggested that in cer-

tain patients the disease process in the lung takes on a special symbolic significance, the character of which is determined by the nature of the patient's personality problem. "The lesion becomes personified and almost seems to be treated as if it had an existence of its own, separate from, but included in, the life of the patient." Hartz reported the case of a patient who unconsciously identified the disease process with her mother. "It was her mother taken inside her who was symbolically being invaded and destroyed by this process." When psychological treatment enabled her to exteriorize the hatred of her mother, the patient's whole attitude toward her pulmonary tuberculosis changed.

The question has been raised why tuberculous patients so rarely commit suicide. The answer has been given that if the tuberculous lesion is regarded and understood as an "organic" suicide or as a "partial" suicide, there is no necessity for the patients to take active steps to terminate their lives.

These views have been supported by Rebner, who, using the Blacky Picture Test and the Rorschach Test, subjected to a careful investigation the role of personality as one of the factors in relapse in pulmonary tuberculosis. His research population consisted of a group of 20 persons, whose tuberculosis had become arrested after a relapse, and of two matched control groups, one composed of individuals recovered without a relapse and the other composed of relapsed tuberculosis patients. Although other factors related to immunity and reinfection undoubtedly played important roles in the relapses, statistical analysis of the results obtained showed (1). that both relapsed groups manifested a greater degree of oral aggression than did the unrelapsed group and (2). that the persons in the relapsed hospitalized group had a greater tendency to direct aggressive drives onto the self than did persons in the relapsed arrested group.

The medical literature is full of articles concerning the relationship between tuberculosis and mental illness. The coincidence of tuberculosis with schizophrenia and other chronic mental illnesses which require prolonged hospitalization is several times greater than is the incidence of tuberculosis in the general population. To point to tuberculosis as a positive agent in the functional psychoses, is difficult, but it can be considered secondary or reactive to the organic illness. Certain transient psychotic episodes during a prolonged hospitalization for tuberculosis are not unusual, with depression and restless irritability associated with paranoid delusional material.

A word about the meaning of the illness to the patient seems in order. In tuberculosis hospitals and clinics there are many men who have performed poorly in most of their social roles and who contract tuberculosis at a time when their hopes for achieving any small success are almost gone. The struggle has already been great and the prospect of resuming this struggle, when they are a little older and with the residuals of a chronic disease, becomes almost unbearable. These are the patients who often seek to consolidate the role of "patient" through emphasis on disability, numerous physical complaints and negation of all rehabilitative efforts. The staff in turn may respond by emphasizing the commonly held principal that tendency toward dependency should be discouraged in the handicapped and they sometimes become frustrated and angry when the patient refuses to "cooperate."

Dr. Paul Chodoff of the George Washington University Medical School, as a result of some of his observations of chronically ill patients, states "there is room for doubt as to whether discouragement of dependency tendencies in the handicapped is always an invariably useful process." He conjectures that "In some cases efforts to combat dependency may produce more comfort in their attendance than in the crippled persons themselves." Hospitals contain a small group of patients who have neither the social nor per-

sonal resources to assume any role other than that of institutionalized patients if the benefit achieved from prolonged and expert medical and social care is to be sustained. Thus, there are some patients who are extremely dependent, have lost capacity for community living, and are unable to muster meager or nonexistent personal resources which might enable them to adjust anywhere but right in the hospital.

By way of conclusion, patients with infectious diseases, as epitomized by tuberculous subjects, tend to be sensitive, anxious, rigid, and emotionally labile. Tuberculous patients, when compared with the cultural norms, are in many ways marginal people at the time of onset of tuberculosis.

The greater the psychosocial assets, the higher the probability that the individual with infectious diseases will be equipped to learn and apply those methods of living which are most conducive to favorable response to therapy. The fewer the assets the higher the probability that the methods of living utilized will perpetuate seriously disrupted homeostasis and lowered resistance.

Good clinicians now support the old dictum that it is "not the disease only, but also the man." It is not the tubercle-bacilli alone that is the cause of tuberculosis, but the status of the man who gets the dose of bacilli in regard to all aspects of both his internal and external environment.

Tuberculosis is a disease which warrants continued research. Some has been done. Much is yet to be done. That it needs to be done is accepted by physician, psychologist, social worker and patient.

And Every State Might Profit By The Survey

Burning one's driver's license would make a lot more sense than burning his draft card, if he is really afraid to die, gently suggests *Texas Medicine*, after stressing some comparative statistics.

These statistics not only point to 2,000 servicemen killed in combat in Vietnam in 1966 as contrasted with 7,000 servicemen dead in traffic accidents in the same year, but it contrasts the pickup time of a few minutes by helicopter from the battlefield to be taken to a hospital staffed and equipped to meet every conceivable need, with the limited ambulance service and the inadequate hospital emergency rooms at home.

A Texas emergency-service survey is disclosing some startling facts such as: Twelve Texas counties have no ambulance services, and 30 counties have no hospitals—much less emergency room facilities. It adds: "We should be concerned about these areas because, although they are sparsely settled, we travel their highways; 70 per cent of all traffic deaths occur in the rural areas."

Traditionally, funeral home operators have provided ambulance service. "They did not seek the role," the article adds, "but accepted it as a community service. The medical profession did not object, and if this service has not been up to standard we share the responsibility.

Recently, several things changed. All employees of the ambulance operators became subject to the minimum wage law, and the cost of keeping an attendant on call became prohibitive since many of the fees for service could not be collected. Thus, many funeral directors and ambulance operators withdrew from this service.

"What were the alternatives? Some cities offered subsidies; others began to operate ambulances either directly or through their fire or police departments. Some have had good results; some have not.

"About 77 per cent of the ambulance services in Texas are still operated by the funeral homes, but probably the number will decrease."

A Patient Speaks

Mrs. Louise Nachman

Last September, when I was asked to speak at this meeting, I accepted happily for two reasons: one, February seemed a safe distance away, and second, in lieu of writing THE book on TB of the calibre of the "Egg and I," or "See Here, Private Hargrove," (as opposed to "Huber the Tuber"), this seemed second best. Second only in that there will be no royalties here. (Parenthetically, I was incapable of writing that book, just as I feel today incapable of speaking before you.) A psychiatrist once told me that one must learn to face discomfort. I have learned that . . . and I am now facing mine—squarely.

I have wondered for quite some time just exactly what would be my point in such a talk . . . a patient speaks. I have found not even a semblance of structure . . . for considering topics—such as treatment, conditions, fellow-patients, etc., has netted me only one thing—reactions. And so, a patient reacts. A sub-title might well be, "13 year old kaleidioscopic impressions of a Tuberculous—with special concern for Mr. Dick's September admonition of honesty."

I cannot say another word until I make clear a very deep feeling; We all know that TB is not the killer it once was, and in comparison with today's killers, it is relatively insignificant. Therefore, please understand that underlying everything I say is not only a certain gratitude, but almost a feeling of what-am-I-making-so-much-out-of-this-for?—almost an apology, because most everyone responds to the drugs and with them the disease is readily controlled. I hope my ambivalence doesn't in any way undermine the cause.

I have also had some pause this fall and winter about the pertinency of what I have to say—because this highly traumatic event took place 13 years ago. This feeling almost made me call Mr. Dick and cancel. However, I remembered Robert Louis Stevenson, Chopin, and Modigliani, and realized that *TIME* does not affect the *ATTITUDE*. Certainly, anything these gentlemen could say to you today would be highly pertinent.

And now, one more explanation. Though I realize my purpose is to give an honest accounting, I also realize that I was not a typical patient of the Montgomery Tuberculosis Sanatarium 13 years ago . . . from the standpoint of educational and social background. As a-typical, I wonder what I can tell you—unless, in some way, I can articulate the feelings, reactions and attitudes of my many inarticulate bed-fellows. I shall try.

I know the majority of you have not had the disease. I gather the majority of you work with it in one way or another. You are experts in the field—and for the first time in my life I am speaking as an expert in mine. Not, necessarily, as an expert patient, but as an expert at being a patient. And for this expertise, I shall forever be grateful! Grateful, because in my case, and I trust in most, a great deal of good came from having had TB. I suppose this can be said of any disease a patient recovers from, but there seems to be a special veil surrounding tuberculosis . . . possibly put there by literature . . . which heightens sensitivity so that one lands, almost, in euphoria. According to Dr. Lawranson Brown, "The TB patient is described as anything between an insane criminal and a saint too ethereal for this mundane sphere." I've often wondered if some of the nurses during my stay didn't think I thought I had become the latter. Possibly they were right because I did feel ethereal. I know that much of my thinking, other than wanting to get out, was certainly on the positive, inspired side. I remember becoming ecstatic over a quotation by Thomas H. Holmes—you probably know who he is, I

don't, which said, "Hospitalization itself serves as the stimulus which brings more or less sharply into focus an awareness in the patient that the relatively fixed way of life terminated by the diagnosis of TB was inadequate for the maintenance of general well being." During the third day of my hospitalization, I wrote: "I have almost too much to do . . . too many projects and a kind of split-up routine that interferes." My old, fixed way of life had ended . . . yet in a sense it continued—but busily in bed.

I suppose at this point it would be appropriate to give you a very brief history of my case. I was eight months pregnant upon admission. Prior to admission, I had been rather acutely ill for one month. I was tested for polio—and thankfully, tested negative. Bi-lateral pleurisy and "Koksaki" disease proved positive. Within a few weeks my planograms confirmed a tuberculosis cavity, and almost at the same time my negative skin test turned positive. A few guinea pigs entered in—at this point—and departed. It was a relief, that end-of summer-day, to know exactly the cause of my total exhaustion, shortness of breath, and impatience! Of course we knew the surest and quickest cure was a sanatarium . . . and though we knew we were indeed fortunate to have one right here in our city, free of charge—moments, big and frequent ones of self-pity would sweep over me and I'd lose temporary sight of our family's luck . . . mine especially. While waiting at home a few days for an available bed at the San, one of my main concerns was not smoking. I remember suffering dramatically over this, almost as much as I did the diagnosis itself. I was proud of my friends who came to see me that weekend, apparently enough educated to know I was a relatively safe risk. They brought me peppermint drops (in lieu of cigarettes) and sympathy, and I fed on both. Way down deep, though, it was like waiting for an execution . . . and almost as bad as the actual moment I was left at the Sanatarium by husband and mother, sitting cross-legged on a white bedspread covering a lumpy mattress—facing 22 white women, all very sick, yet happy and bouncing and—staring. I stared back because I couldn't get over seeing old ladies in pajamas! Case No. 309 was in shock.

Case No. 309 soon learned, however, that smoking was permissible, and though now I'm sorry I didn't stop altogether, cutting six cigarettes in half, meant 12 guaranteed, genuine moments of pleasure each day.

I immediately began to gorge myself on slogans . . . "Don't just accept necessity, learn to love it." "The better your attitude of cooperation . . . physical, mental and emotional, the quicker you'll get home." "The light touch," etc. And then commands: "Knit, read, writing, start projects, write poems to family, write poems to the Democrats (about to lose the '56 election), write poems to that unborn child." Thought control had to be developed and I believe I succeeded—with those edicts, as well as employing various tricks of mind. I pretended I was starting my pregnancy all over—with Grace Kelly who had just begun hers; I pretended I was a baseball player getting a job in a men's clothing store—yearning for spring training, and knowing it would come. I read novels in which a week took up a paragraph; or a month, one page; better still, a year covered in less than a chapter. These devices were used day and night . . . and when I HAD to take a look out into the world, it was with a spy-glass, focused on a single subject and very limited. I often wondered if the nurses thought I was in the right state institution! I do remember that nothing helped, no trick, no slogan, nothing, in the very early morning —and I should like to suggest that you nurses on the early morning shift be especially understanding. There are a few moments between awaking and becoming fully conscious when there remains residue from the night's off-center thinking. Those moments—short-lived as they were, put me in panic. I'd awake to hear roommates shuffling through their bedside tables looking for snuff boxes—sounding like mice; and I'd look out the win-

dow and see the milk truck—so sane and worldly. I would wonder who I was—knowing that I wasn't an American Indian, Eskimo, or prisoner of war. (How wrong I had been about the kind of people who get the disease!) As the milk truck left, the day got lighter, coffee came, and the panic left as the routine began. The hospital regimen is indeed a blessing—and on top of it, I had my own. Nurses feature greatly, of course, in this regimen. And yet I was always very ambivalent about them . . . hating them for their freedom in their white starched uniforms and blue wool capes . . . looking so smug; and at the same time, loving them for what they represented—freedom and health and normalcy. I wanted them around me as much as possible, and luckily, they seemed to like my corner.

I had very little in common with the woman next to me—except for two rather important features—a heart and tubercle bacilli. In the beginning, I took refuge from her behind a caladium plant on my bedside table; as I took refuge behind books from many others. There were, however, a few women with whom real friendships developed. Within the first 45 minutes of what was to become a six months stay, I met a friend who remains my closest friend today. Without her—and I shall call her Ann—I doubt if my adjustment would have been smooth at all. Without me, she tells me, her departure might have ended AMA. She was clever, she was intelligent, we had friends and experiences in common, but most of all she made me laugh. One morning, early in the disease, she called across the corridor (our two wards had walls which didn't go to the ceiling and were separated only by a narrow hallway) "If you ever do write that article on TB, be sure to put in it that part of the cure MUST be grits and hotdogs!" We were often hysterical—and wondered if our INH had anything to do with it. Once she said, "Dr. Oliver doesn't believe in saying 'how do you do'—he just puts out his hand and says 'six to eight months'."

My baby was born one month to the day after I entered. She was healthy and here—for which I was thankful, yet waiting for her birth—which meant having her with me, the many nickels we all bet as the time of it, the nurses getting frantic over not wanting it to happen on their shift, the general excitement of anticipation, was something I was to miss. If I didn't have the first white baby born in the Montgomery sanatarium, I at least said I did; and the event became all the more of interest when my in-town obstetrician let it be known that that morning at dawn, as he held a 45 minute old baby in his arms and drove her to St. Margarets, he felt like the Lindberg kidnapper.

So once the delivery was over, I was strictly nothing but tuberculous; and I began to settle down and take my illness seriously. I had no desire to have a negative sputum so that I could get into the San station wagon and see a football game on Friday night! If I was sick enough to be isolated in a sanatarium—five short miles from home, my plan and desire was to stay in bed. Besides, I didn't like football, and other than being with Ann and a few others, I preferred to stay with my books—in bed. I tried to stay away from Bible classes, prayer groups and chapel on Sundays for this very reason—but eventually felt in order to survive socially in the ward, I would have to make a few concessions. So I began going, mainly because the Chaplain was attractive. Also, I had a hidden desire to integrate the chapel. I sat on the negro side a couple of times without causing a ripple . . . much to my disappointment. Later I decided I didn't care if I was a social-religious flop, and so I stayed in bed and read . . . becoming well acquainted with a spider in its web above me and a crack in the stucco outside my window which housed a lizard.

I developed a regular reading program. Books on the disease were read after breakfast—when my mind was somewhat alert and my curiosity at its height. Frivolous novels were for after afternoon rest—some-

times, though, read under the sheets DURING rest. Inspiration books at night with the hope that serene sleep might follow. Morning reading often brought me such gems as Dr. Osler's "The cure of TB depends more on what the patient has in his head than on what he has in his chest." I fed on that for months—because such fresh breezes had an immense carrying effect. Many similar insights developed and a relative peace of mind descended on me. I knew that a newcomer could not be convinced of the actual good fortune involved . . . that it had to be self-concluded. Yet we tried with each one, with each freshman, newly admitted—for whom we felt great wafts of pity and also great scorn, because she took us back to our own first moments of terror and horror. Many hours were spent in the bathroom after lights out—9:00, futilely trying to tell them that TB was nothing to be ashamed of. (Their ignorance about the disease eventually ceased to shock me.) The majority of white women with whom I lived, knew nothing about their diseases nor seemed to care to know. After their first (and only) personal interview with the Doctor, there were few questions asked—if any—about whether their cavities had closed, their TB spread. Possibly I envied the type of philosophy I heard so often . . . "If it's the Lord's will to let me git well, then I will. If it ain't, then I wont." Snuff drooling from the mouth cut off my envy.

Yet with every drop of snuff, with every hideous grammatical error, I was learning—by living with people I would probably never live with again, hopefully. But because I was, I knew my eyes were opening. They were opening to depressing sights . . . just seeing so many forms in bed was in itself depressing—the forms made visible by the light of 11 exit signs seen from my corner. To realize that for 8 months I would wear pajamas and chew juicy fruit gum, was depressing. To realize that my new friends thought I was for all purposes doomed, because I didn't crochet, read the Bible nightly, and swore occasionally—depressed me. To realize how utterly lacking in any kind of glamour were their lives—how they would have to spend their well time on earth cooking, sewing and "arning" for their younguns, hurt to the quick. To realize they didn't know what Ann and I were talking about when discussing the morning's Alsop column, or the news on the Today show, depressed me. Hearing sputum raised at mealtime; listening to the bathroom door open and shut all night long; writing letters to several different daddies for several different daughters —who didn't know how - - - all causes of severe depression, yet, if so wished, things on which I could sharpen my soul.

Being somewhat verbal, I was often elected to report irregularities, signs of uncleanliness (and there were many), request for favors, and complaints about poor menus. (It is a fact that those who complained the most about the food were the ones who probably subsisted on bread, coffee and occasional vienna sausages.) For this reason, I wouldn't be surprised if the staff, most especially Cleo Crain, didn't think of me as an outright trouble-maker. I don't believe I really was . . . but am willing to suggest that perhaps it appeared that way. I do remember one Sunday being enough exorcised over cockroaches under and on our beds that I didn't wait for the election. The exterminator arrived the next day.

So much has been written about the importance of rapport between staff, doctor, and patient. I believe the Sanatarium rated high on rapport between staff and patient, and really quite low between Doctor and patient. For one thing, our Doctor was overworked. He was Doctor, Administrator, Dietician, Kind. I don't believe he had any idea how much we depended on his presence. When he went to Chicago to study anesthesia for two months, we felt in a crisis situation. Othertimes, when he would leave the hospital at his regular hour—4:30, and each weekend when he wasn't there at all, we felt in a similar, though smaller crisis. It was not

that we feared an emergency, but his being away pointed up our alone-ness. You see, a TB patient feels like so much cattle to begin with—and when the Doctor wasn't around, we felt at pasture. Weekends were always black. Only three hours for visitors and almost total alone-ness. I wonder if that situation remains today. Is there not some way that a little more authority might be on hand on weekends? But with the depression of a weekend, came, then, the anticipation of Monday . . . with all its busy-ness and activity. Security would set in once again for five days.

TB is so often discussed statistically and called the "statistical disease." Whereas, this disease, almost more than any other, I should think, should be considered in personal terms . . . because of its duration; because as an isolated human, one tends to feel like an isolated "thing"; and because the patient's former mode of living is completely interrupted and he enters, practically, a whole new world. We were people . . . not statistics, and we were all kinds of people. Most of the time we were treated like people. If I were to complain on this score, it would be that I was treated as people all of the time. Was it because board members were my friends? Dr. Osler's remarks about the importance of what's in the patient's head should have great significance for the staff, too. The staff can help in building proper attitudes, especially in cases when the family reacts conversely; in helping the patient feel human, wanted, useful, happy, and in helping him develop perspectives, whole new hobbies, interest and thoughts.

At the time I was there, only one Doctor from town, who occasionally saw patients or took over on a temporary basis, wore a mask when with us. It is almost impossible to describe to you the effect that mask had on me! It had the immediate power of undoing all the good from all the good quotations I had read. Of course, I know that wearing the mask was his right . . . perhaps he had a cold each visit and was trying to protect us—or perhaps he simply wanted to be completely safe. Whatever his reasons, the mask had such a negative effect that I didn't even try to understand. Obviously, I was unreasonable—but I had been told that visitors were safer with us than they were at a neighborhood theatre. It hurt a bit.

I would like to end on the fun we had, because especially in looking back, and even while it was happening, there was fun . . . a great deal of it. There was the fun of being treacherously sick and yet not really feeling sick; there was fun in receiving so much attention from within the hospital and without. There was fun in killing time by shaving legs, creaming hands, rolling hair. One patient spent several hours each day throwing her hip out of place. If you looked at it in a special way, there was fun in doing absolutely nothing—in spending days, weeks and months working no harder than dialing a pay telephone. Nightly prune juice at the nurses station was a highlight—along with the overall college dormitory atmosphere—even though at a fifth grade level. It WAS fun, if you kept the spy glass in the table and didn't look out at the world too often. And there was a warm feeling of well-being when you could get involved in others' problems . . . their hemorrhages, their hemorrhoids, their upsetting letters from home. When someone cried, everyone was involved. There was not only a TB discipline, but a TB temperament. I often wonder if I have retained it.

One quick word about men . . . and it can be said in a word. We were all in love with our Doctor, our Chaplain, and Perry Como. And somehow, miraculously, like everything else, these loves sustained us—and sufficed.

I have had 13 years now, since all of this, to sleep on percale sheets, to drink orange juice, to talk on the phone without using a tissue, to love and to hate, to cry and be happy. Every bit of it means more to me—because I was lucky when I faced the cold, blue terms of tuberculosis—and got well.

Volunteers and Tuberculosis

K. W. Grimley

Frederick Lewis Allen, the great Editor-in-Chief of *Harper's* in the days when that magazine was perhaps the single greatest former of intellectual opinion, once tried to define in a series of articles his idea of the American way of life. "The unsystematic American system" he called it.

Groping for the key to the difference between American and the totalitarian countries, he was forced to conclude it was not, really, in our formal structure of government. We too, now have a very large and powerful central government; and its authority grows, not only because of wars hot or cold, and seemingly not merely because of our growing interdependence and urbanization; but also as if in response to some irresistible natural law. Beneath its shadow, even the sovereign states grow small.

But at last Mr. Allen came to what he thought of as the key. At first glance, it is an insignificantly appearing social phenomenon, to serve as the great water shed between cultures. It is the existence, in our society of "the extraordinarily wide and proliferating assortment of *voluntary* institutions, associations and societies which in their manifold way contribute to the public good."

Continued Mr. Allen, "It is fair to say that the moral and intellectual strength of the United States is based in considerable degree on private organizations which are as consecrated to the idea of public duty as governmental ones could be, but provide at the same time vastly more diversity and flexibility of approach, and vastly more opportunity for the free play of individual talent and interest."

Almost exactly a century earlier a great French early traveller to America, Tocqueville, observed "wherever at the head of some new undertaking you see the government in France, or a man of rank or the Nobility in England, in the United States you will find an *Association.*"

A tuberculosis association is a group of private citizens. Hopefully it is representative of the community; composed of doctors, lawyers, merchants, sometimes thieves. Recognizing Osler's dictum that tuberculosis is not a medical problem with a social aspect but a social problem with a medical aspect, it must be composed of laymen as well as professionals. The men and women who compose it are interested as private citizens, in the public problem of public health. Hopefully, they recognize the fact that tuberculosis and respiratory disease is not all of public health and that the control of these diseases cannot be achieved without general measures for the protection of the public health against all enemies.

As you know, this organization has a financing device: The Christmas Seal. From this device certain relatively small but constant sums of money may be obtained from private contributions for the execution of the program of the association.

This financing device relates the three levels of organization, local, state and national associations, much as the device of taxation binds together local, state and national governments. I must add that in our organization, too, the state is presumed sovereign; however, I must also report that at the present time we have a very violent states rights controversy. As a matter of fact the Board of Directors of the National Tuberculosis and Respiratory Disease Association is meeting in New York to make far reaching decisions which may result in greater centralization in this voluntary movement.

Mr. Grimley is Executive Director of the Alabama Tuberculosis Association, Birmingham.

Our first principle of program building is the importance of health education. In the words of Edward Livingston Trudeau, first president of the National Association, "Education of the people and through them of the state, is the greatest need in the control of tuberculosis."

This emphasis on health education goes back as far as the magazine article by Jacob Riis in 1907 which first suggested the idea of the Christmas Seal. Quoting from a paragraph from that article: "Tuberculosis is just such a wrong. Nothing in all the world is better proven than that it is a preventable disease and therefore needless. And yet in our own country it goes on year after year, killing an army. Perhaps I feel strongly about it. It killed six of my brothers.

"What I want to know is why we cannot borrow a leaf from Denmark's notebook and do as they have done. Why should we not have a Christmas Stamp, printed by a tuberculosis committee, and sold not for the purpose of building a hospital—let each state build its own—but for the purpose of rousing up and educating the people on this most important matter. It is because they do not know a few amazingly simple things that people die of tuberculosis."

Education is such a broad subject that I have time to touch on only two aspects of it. First, education of ourselves and of our leaders is just as important as the education of the masses of people. If in a given county we succeed in organizing a tuberculosis association composed of 15 or 20 community leaders from all walks of life, our most important task and our most challenging opportunity, is the education of these 20 people on the importance of the protection of the public health.

The second fact is that education is done by doing, as well as hearing. There is an education by example or demonstration. Since the tuberculosis associations were the first of all the voluntary health associations it is not strange that we have pioneered in many things. The first Public Health Nurse in Alabama was hired not by a health department but by a tuberculosis committee in Walker County. This nurse doing what we now call public health nursing, was an educational device, the value of which has gone through these years far beyond the relatively few homes she succeeded in visiting. The first tuberculosis hospital in Alabama was started not by the state or any county or city but by private citizens interested in educating their community to the fact that tuberculosis could be cured. The first chest X-ray, the first photofluorogram taken in Alabama were taken as educational devices by tuberculosis associations. The first chest clinic in Alabama was organized by a tuberculosis association as a demonstration to prove to the tax payers and to the tax appropriators the importance of case finding and the possibility of outpatient care of tuberculosis.

The second basic principle of our volunteer program is concerned with the matter of cooperation with and support of official agencies. We feel very strongly that our cooperative support must be provided for the programs of the health department, the tuberculosis hospital, the Division of Vocational Rehabilitation, the Welfare Department and all other branches of government dealing with the public health.

But if we are to cooperate and support, we must be familiar with the definition of these words. To cooperate means to act or operate jointly with one another. To support means to hold up, to promote the course of, or possibly to pay the cost of.

The easiest way to support an official agency may be to give the money necessary to get a particular job or project done. But this kind of support rarely carries with it any real degree of cooperation, because the element of joint operation is so often removed.

Direct financial support of official projects by tuberculosis associations actually may

weaken both the official agency and the association.

So often a very small sum of money is appropriated by tuberculosis associations or committees to a county health department for some specific purpose, such as the employment of an additional Public Health Nurse. This small grant forthwith indefinitely postpones acceptance by the official appropriating bodies, of their responsibility of meeting as only the powers of government can do, the full needs for public health nursing.

There are times of course when a volunteer association should aid in financing an official project but such support should be given only after joint consideration of the relative need for the project, the future availability of tax funds for its support, and the steps that must be taken in the future to shift the full financial responsibility to the official agency.

Presently the voluntary tuberculosis movement has four objectives. Two of these might be termed primary and two secondary.

The first is the *eradication* of tuberculosis. The second is the *control* of the other respiratory diseases such as emphysema and chronic bronchitis. The third is the reduction of community air pollution and the fourth is the reduction of cigarette smoking. These are large aims and their accomplishment is far off.

Let me remind you of an advertisement which appeared in many media which I am sure you have seen. It was placed by the American Petroleum Institute. There is a photograph of a muddy field, a crude airplane, and a bleak, tumbled-down shed. And two mud-spattered figures, on their faces the marks of care and discouragement, as though something unpleasant had recently happened. One of them is Wilbur Wright; the other is a woman whose name is lost in the mists of time. She is believed to have been America's first woman pilot. The date line is 1903. The headline says "They were free to put their time, energy and money into A CHALLENGE TO THE IMPOSSIBLE."

In almost that same year a small handful of men gathered in a room in Atlantic City and faced the fact that a million and a half of Americans were doomed to die before the Captain of the Men of Death, the great white plague. These men were free also to put their time, energy and money into a challenge to the impossible; and the National Tuberculosis Association, the first of the voluntary health agencies, was born.

We who are working in the voluntary health movement believe that we are harkening to the words of Laurence Gould when he said "I do not believe the greatest threat to our future is from bombs or guided missiles. I do not think our civilization will die that way. I think it will die when we no longer care. Arnold Toynbee has pointed out that almost all of the 21 civilizations which have passed away died from within and not by conquest from without. There were no bands playing and no flags waving when these civilizations decayed. It happened slowly, in the quiet and the dark when no one was aware."

We like you also believe in the words of Abram Sachar "If the day comes when the American people cry out that they are tired of problems, tired of being responsible for the well being of others, and there is no longer a response to the pain of others, then we shall not be worthy of our heritage as Americans."

The growth year by year of the voluntary tuberculosis movement and of the official agencies of public health as you represent, is evidence that that day is not yet.

Who Are Medicine's Enemies?

A letter-to-the-editor, answering an extravagant attack on the AMA by a young medical student, states succinctly medicine's current status. Signed by a Seattle M. D., it states in part:

"The AMA has a tremendous job trying to keep the practice of medicine free from interference, free from the government, free from the insurance companies, and free to compete on the open market. They are not just fighting 'against' socialized medicine; they are fighting for something they know is good and works, if it is left alone to work unhampered.

"After 25 years of practice in this area, this Oregon medical school graduate can report the greatest interference in the private practice of medicine comes from doctors, not in the AMA but in the local hospitals and in the local county medical service corporation. Next in line come the insurance companies, which would like to control your fees and the relationship with your patients. And finally, 'coming up rapidly,' is Medicare. These organizations would like to control not only your fees, your practice of medicine, but also your judgment. The AMA knows that. They also know the 'group health type of organizations' represent insurance controlled practice of medicine with certain disadvantages to the patient as compared to private practice. The AMA knows the taxpayers' money (our young student refers to it as Federal Aid) goes only so far and no further, and that when the Federal government uses it to help students or medical schools or Medicare or Social Security there have to be strings attached. When strings are attached they interfere with the private practice of medicine.

"The private practice of medicine is still the backbone of medical care in the U.S., at least as compared to England's socialized medical system. It is both better for the patient and the doctor, or so I am told by friends who have been there to practice. The AMA is doing yeoman's work in keeping it that way."

Compulsory Contraception

Mandatory participation in birth control is repugnant to most Americans. For one thing they resent compulsion in any phase of their lives. More importantly, that would interject the government between a man and his wife . . . and between a couple and their moral or religious beliefs.

Education, moral persuasion without compulsion, and the availability of counseling services seem to be the best mechanisms we have to carry out an effective program. In any event, any successful program must be carried out through joint efforts of many disciplines in the total health care team—physician, sociologists and social workers, public health and public welfare personnel, educators, economists, and the clergy. But whatever program is undertaken, the primary concern must be to respect the individual.

In this area, as in all others, we cannot sacrifice the individual for even what we know to be the good of society in the future. If the individual does not participate willingly in building it, then the society of the future won't be worth having.—AMA President Dorman, as quoted in The *Journal* of the Medical Society of New Jersey.



Campbell's Soups... wide variety...for limited appetites

Many people lose interest in food as they grow older. Some of them are fussy eaters—with only a few favorite foods. Others become indifferent to foods—because planning and preparing meals becomes a chore. Here Campbell's Soups can help —for these four very good reasons:

Appeal With a variety of tastes, textures, aromas, and colors, Campbell's Soups can add interest and appetite appeal. And they're easy to eat—ingredients are tender, bite-size. Even patients on special diets will find soups they can enjoy among the more than 50 different varieties available.



Nourishment Campbell's Soups contain selected meats and sea foods, best garden vegetables—carefully processed to help retain their natural flavors and nutritive values.

Convenience Within 4 minutes a bowl of delicious soup is heated and ready to eat.

Economy Campbell's Soups are inexpensive—an important consideration to those whose budgets are limited.

Recommend Campbell's Soups . . . and, of course, enjoy them yourself. Remember, *there's a soup for almost every patient and diet . . . and for every meal.*

This is the "answering service" your patient takes home with her...



included in her Compackage™ sample of

Helpful booklet saves unnecessary phone calls—Reminds her of your directions concerning her oral contraceptive schedule . . . contains supportive instructions for "Sunday starting". . . explains in simple language many aspects of "the pill."

Packaging helps her stay on schedule—The Ovulen Compack®, with each tablet designated by day and week of cycle, shows at a glance the last day on which a tablet was taken.

Each white Ovulen tablet contains 1 mg. ethynodiol diacetate and 0.1 mg. mestranol. Each pink tablet is a placebo, containing no active ingredients.

Ovulen®-21
Ovulen®-28
"the convenient one"

NOTE: For the budget-minded woman specify Triopak™, a three-month supply (1 Compack and 2 Refills).

Actions—Ovulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis and pulmonary embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable. Retrospective studies in Great Britain and the United States have shown a statistically significant association between cerebral thrombosis and embolism and the use of oral contraceptives.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen. Therefore, if such tests are abnormal in a patient taking Ovulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives.

The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

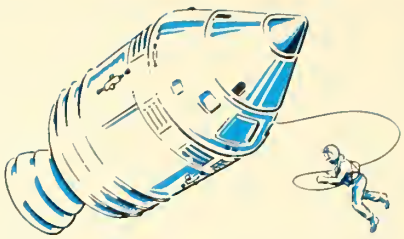
The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651:657 (June 14) 1969. **4.** Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.



SEARLE Where "The Pill" Began 976

G. D. Searle & Co., P. O. Box 5110, Chicago, Illinois 60680



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals



around the state

New Physicians Licensed To Practice In Alabama



George Alfred Azar, M. D., Indiana University School of Medicine, 1964, Reciprocity with Indiana —Intends to locate in Andalusia.



Edward Marion Holmes, Jr., M. D., Georgetown University School of Medicine, 1933, Reciprocity with Virginia—Intends to locate in Birmingham.



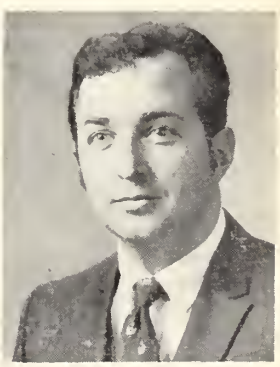
Edna Phillips Fuson, M. D., University of Louisville School of Medicine, 1966, Reciprocity with Kentucky—Intends to locate in Winfield.



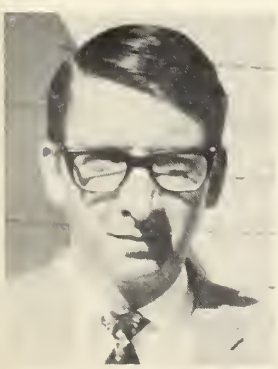
Robert Jerald Hornsby, M. D., University of Tennessee College of Medicine, 1961, Reciprocity with Mississippi—Intends to locate in Huntsville.



Vernon Ray Fuson, M. D., University of Louisville School of Medicine, 1967, Reciprocity with Kentucky—Intends to locate in Winfield.



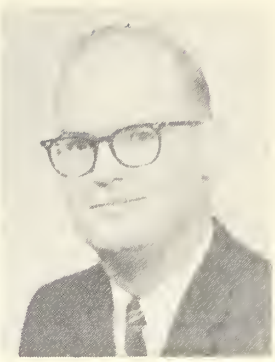
Lynn Crook Koenemann, M. D., University of Alabama School of Medicine, 1966, Reciprocity with NBME—Intends to locate in Birmingham.



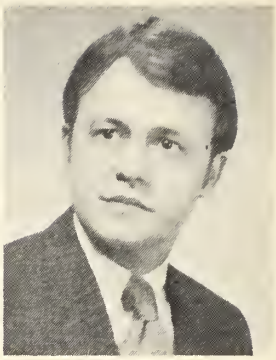
Joseph Gruber Hayes, M. D., Georgetown University School of Medicine, 1963, Reciprocity NBME—Intends to locate in Covington County (Eglin A. F. B.)



Daisy Si Lee, M. D., Bowman Gray School of Medicine, 1961, Reciprocity with California—Intends to locate in Birmingham.



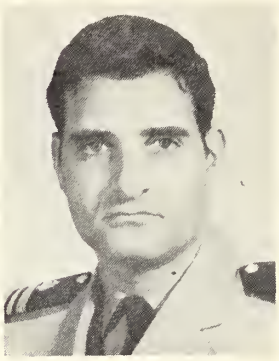
Walter Crawford Owen, Jr., M. D., University of Mississippi School of Medicine, 1962, Reciprocity with Mississippi—Intends to locate in Birmingham.



Dean Beaury Talley, M. D., Medical College of Georgia, 1968, Reciprocity with Georgia—Intends to locate in Birmingham.



Arthur Eugene Parker, M. D., University of Mississippi School of Medicine, 1965, Reciprocity with Mississippi—Intends to locate in Atmore (Part-time)



Allan James White, M. D., State University of New York Downstate Medical Center, 1964, Reciprocity with NBME —Intends to locate in Pensacola, Florida (U. S. Navy).



William Edward Steiner, M. D., University of Illinois, 1937, Reciprocity with Illinois—Intends to locate in Tuscaloosa (VA Hospital).



Harold Cyril Woodworth, M. D., Harvard Medical School, 1944, Reciprocity with NBME —Intends to locate in Colbert County (County Health Officer).

12 County Societies Unreported Last Month

County Medical Society officers for 1970, unreported last month:

AUTAUGA:—James Frederick Stanley, president; Walter Eugene Parker, vice president; Jackson Bernard Dismukes, secretary-treasurer.

BUTLER:—Aubrey A. Stabler, president; Paul A. Stabler, vice president; E. V. Stabler, Sr., secretary-treasurer.

CALHOUN:—B. D. McAnnally, president; E. W. Branyon, Jr., vice president; C. Neal Canup, secretary; George W. Gibbins, treasurer.

CHAMBERS:—Ellann McCrory, president; S. C. Simmons, Jr., vice president; George W. Patterson, secretary-treasurer.

CLEBURNE:—F. E. Mercer, president; D. A. Justice, vice president.

GENEVA:—R. L. Martin, Jr., president; John C. Miller, vice president; Otis D. Mitchum, secretary-treasurer.

HALE:—C. E. Singleton, president; D. R. Ramey, vice president; W. C. McAdory, Jr., secretary-treasurer.

HENRY:—J. R. Shell, president; W. T. Creel, vice president; J. R. Shell, secretary-treasurer.

JACKSON:—T. A. Gibson, president; I. W. Bankston, vice president; H. Grady Jones, secretary-treasurer.

MACON:—H. W. Foster, president; Luther C. McRae, Jr., vice president; S. H. Settler, Jr., secretary-treasurer.

MARSHALL:—Braxton F. Smith, president; Robert R. Roper, vice president; E. W. Venning, secretary-treasurer.

TALLAPOOSA:—W. E. McDavid, Jr., president; John Robert Chapman, vice president; A. Jerry Swindall, secretary-treasurer.

Vital Statistics

NEW MEMBERS

Calhoun County

Bryant, Kirby Knapp, Jr., b 30, mc Harvard 56, recip. Miss. 69, 700 E. 10th St., Anniston, Alabama 36201. U

Clark, Charles Francis, b 39, mc Johns Hopkins 64, recip. Colorado 69, Noble Army Hospital, Fort McClellan, Alabama 36201

Elliott, Mary Catherine Turner, b 41, mc Univ. Miss. 67, recip. Miss. 69, 3310 Henry Road, Anniston, Alabama 36201. GP

Coffee County

Ferlisi, Joseph Angelo, b 33, mc St. Univ. N.Y. 59, recip. NBME 69, Medical Arts Bldg., Enterprise, Alabama 36330

Mitchell, William Lloyd, b 37, mc Alabama 63, sb 64, 207 E. Brunson Ave., Enterprise, Alabama 36330

Monzingo, George Franklin, b 36, mc La. State Univ. 61, recip. La. 69, Enterprise Hospital, Enterprise, Alabama 36330

Colbert County

Pieroni, Daniel William, b 40, mc Indiana Univ. 65, recip. Indiana 69, 1111 So. Raleigh, Sheffield, Alabama 35660. Oph

Woodworth, Harold Cyril, b 20, mc Harvard 44, recip. NBME 70, Colbert County Health Dept., Tuscumbia, Alabama 35674. PH

Dallas County

Hagood, Joseph Herrin, Jr., b 37, mc Univ. Tenn. 63, recip. Miss. 69, P. O. Box 557, Selma, Alabama 36701

Reeves, Hugh Mallory, b 37, mc Tulane 62, recip. La. 68, Swift Bldg., Selma, Alabama 36701

Etowah County

Batson, Paul James, Jr., b 23, mc Univ. Tenn. 51, recip. Tenn. 69, Medical Arts Bldg., 303 Bay St., Gadsden, Alabama 35901. ObG

Campbell, John Hugh, b 34, mc Alabama 63, sb 64, Medical Arts Bldg., 303 Bay St., Gadsden, Alabama 35901. S

Holley, Hilmon DeWitt, Jr., b 35, mc Alabama 61, sb 62, 948 Forrest Ave., Gadsden, Alabama 35901.

Franklin County

Windham, Andrew Allen, b 18, mc Univ. Tenn. 45, recip. Miss. 69, 101 E. Montgomery St., Russellville, Alabama 35653. GP

Jackson County

Elmore, Horace Levoy, b 25, mc Tenn. 55, recip. Miss. 56, Box C-5, Bridgeport, Alabama 35740

Jefferson County

Bennett, Joe Claude, b 33, mc Harvard 58, recip. NBME 59, 1919 7th Ave. So, Birmingham, Alabama 35233. I

Bowen, Robert Klien, Jr., b 39, mc Alabama 65, sb 66, 1615 No. 25th St., Birmingham, Alabama 35234. S

Bush, Stephen Thomas, b 36, mc Georgetown 61, recip. NBME 69, 1025 So. 18th St., Birmingham, Alabama 35205. Path.

Carmichael, Robert Glenn, b 37, mc Univ. Pa. 61, sb 62, 2016 10th Ave., So., Birmingham, Alabama 35205

Coyle, Daniel Joseph, Jr., b 35, mc Alabama 61, sb 62, 214 Medical Arts Bldg. Birmingham, Alabama 35205. S.

Finchum, Robert Newell, b 36, mc Tenn. 60, recip. Tenn. 69, 1919 7th Ave. So., Birmingham, Alabama 35233. C-I

Friedman, Benjamin, b 04, mc Washington Univ. 31, recip. NBME 33, 700 So. 19th St., Birmingham, Alabama 35233

Hardy, Gordon Barnett, b 36, mc Tulane 62, recip. La. 65, Lloyd Noland Hospital, Fairfield, Alabama 35064.

Hazigeorgiou, George Panayiotis, b 29, mc Athens, Greece 58, sb 69, 1211 So. 27th Place, Birmingham, Alabama 35205.

Lewis, Irwin, b 33, mc McGill Univ, Canada 58, recip. NBME 69, 418 Medical Arts Bldg., Birmingham, Alabama 35205. N.

Nieman, Kurt Max Walter, b 32, mc Alabama 60, sb 61, 619 So. 19th St., Birmingham, Alabama 35233. Or.

Rollins, James Letcher, b 34, mc Tenn. 62, recip. Tenn. 69, 801 Princeton Ave., S.W. Birmingham, Alabama 35211. N

Russakoff, Alex David, b 38, mc Tufts Univ. 62, recip. NBME 69, 1211 27th Place, So., Birmingham, Alabama 35233. I

Rutherford, Charles Langdon, Jr., b 37, mc Alabama 63, sb 64, 1919 7th Ave., So., Birmingham, Alabama 35233.

Thomas, Edward Lamar, b 39, mc Alabama 63, sb 64, 1538 Somerset Drive, Birmingham, Alabama 35209.

Thung, Nalda Sylvia, b 29, mc Univ. Indonesia 53, Limited Lic. 69, 619 19th St., So., Birmingham, Alabama 35233. Anes.

Whites, Jack Cannon, b 33, mc Univ. Miss. 59, recip. Miss. 69, 1500 6th Ave., So., Birmingham, Alabama 35233. GP

(Continued on Page 1034)

Synthroid®
(sodium levothyroxine)

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (non-toxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **Injection** is indicated in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. When a patient does not respond to oral therapy, SYNTHROID (sodium levothyroxine) injection may be administered intravenously to avoid any question of poor absorption by either the oral or the intramuscular route.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction.

Side effects: The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism: sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

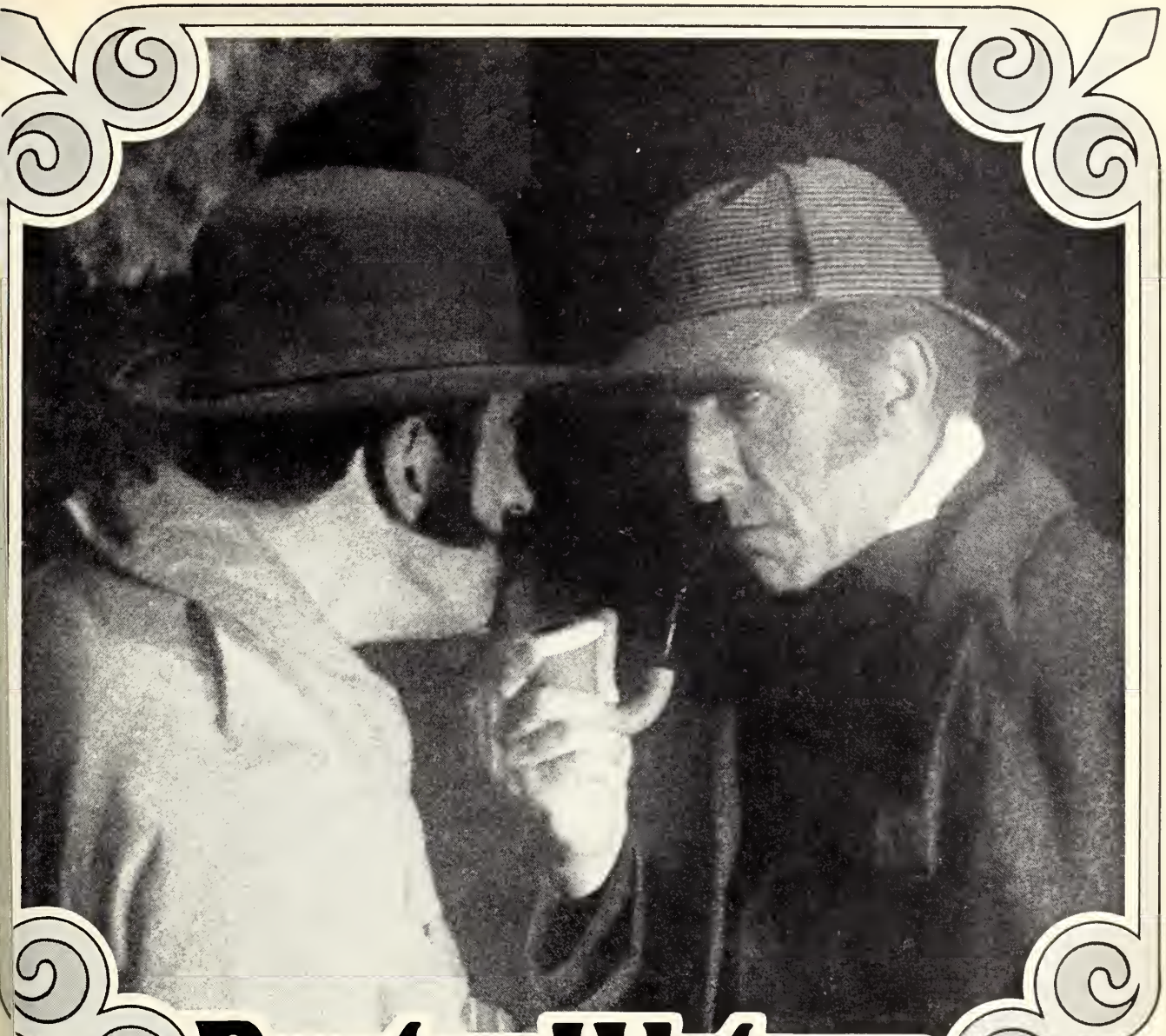
In most cases with side effects, a reduction in dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100 and 500. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent.

SYNTHROID (sodium levothyroxine) INJECTION may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Morton Grove, Illinois 60053



Doctor Watson exposes a double agent

Fo on the Embankment. Two figures emerge into silhouette against a ha ed street lamp. The flare of a match reveals the profile of Sherlock H mes. As he lights his calabash, his companion speaks:

"I Jove, Holmes, that amazing intuition of yours has proved right ag n. What we're looking for is a single entity. I thought we were de ing with several others—even twins. But now—I'd say we've ur overed a double agent."

"ll me more, Watson, and be quiek about it!"

(W tson withdraws a folded paper from inside his greatcoat, and re s aloud from it):

"e key to the whole cypher is SYNTHROID (sodium levothyro ne)"...

"Shh! Watson, not so loud! You'll alert our quarry."

(W son continues): "A single entity that serves two functions."

"A naster stroke, Watson."

"F low along, Holmes. In the neighborhood of 95% of the circulating hyroid hormone is levothyroxine—T_4 as you call it. T_4 is bound to yroxine-binding proteins in the serum. It becomes available only gr ually to tissue cells—as free thyroxine."

"Is that why there's such a smooth, predictable response, Watson?"

"Quite! With agent T_4, SYNTHROID, the chances of a precipitous rise in metabolic rate are lessened."

"But how does 'free' thyroxine fit into the picture?"

"Well, Holmes, you might call it the tissue thyroid hormone—because 'free' thyroxine (that is, thyroxine not bound to protein) is active at the tissue level. It is gradually released from thyroxine-binding proteins. Each daily dose of SYNTHROID is mostly bound to thyroid-binding proteins, and slowly released as 'free' thyroxine—the form in which it is metabolically active."

"Magnificent, Watson! So protein-bound thyroxine is the major form of circulating thyroid hormone, and it is released as 'free' thyroxine. And that's why SYNTHROID is able to simulate the normal proeess so artfully. Q.E.D."

"Not so fast, Holmes. SYNTHROID works for the *physician*, too. Because its dosage is more precisely controllable, and because response is so smooth and predictable, the *doctor* gets fewer phone calls in the wee hours from agitated patients. Both parties get more sleep!"

"Comforting, my dear doctor, to know that SYNTHROID, the 'single agent,' cleverly does the job of two."

Synthroid® (sodium levothyroxine)

(Continued from Page 1032)

Wiltsie, Robert Edward, b 26, mc Alabama 57, sb 58, Lloyd Noland Hospital, Fairfield, Alabama 35064. GP

Lee County

Himmelwright, James P., b 38, mc Northwestern Univ. 63, recip. New Mexico 69, Medical Arts Center, Opelika, Alabama 36801

Limestone County

Roberson, Charles Daniel, b 36, mc Univ. Tenn. 62, recip. Tenn. 69, Sanders St., Athens, Alabama 35611.

Madison County

Mosley, Everett Cole, b 31, mc George Washington 57, recip. Ga. 69, 205 St. Clair Ave., Huntsville, Alabama 35801. Anest

Ray, Harold Cotton, b 40, mc Univ. Tenn. 63, recip. Tenn. 69, 905 Madison St., Huntsville, Alabama 35801

Montgomery County

MacGuire, Hugh Cameron, b 18, mc McGill 43, sb 47, 1766 Pine Street, Montgomery, Alabama 36106. PdS

Scanlan, Joseph Maurice, b 36, mc Univ. Louisville 62, recip. Ky. 69, 750 Washington Ave., Montgomery, Alabama 36104. Oph

Mobile County

Brown, Charles Herbert, b 37, mc Tulane 63, recip. La. 65, 1720 Springhill Ave., Mobile, Alabama 36604

Tuscaloosa County

Brahen, Louis, b 23, mc Jefferson Med. Col. 55, recip. Pa. 67, Druid City Hospital, Tuscaloosa, Alabama 35401

Bright, William Allen, b 31, mc Miss. 64, recip. Miss. 69, 427 University Blvd., Tuscaloosa, Alabama 35401 R

Wheeler, Joe Ann Luker, b 39, mc Alabama 65, sb 66, Student Health Center, University, Alabama 35486

TRANSFER OF NON-MEMBER TO MEMBER

Calhoun County

Strange, Charles Edwin, b 35, mc Tenn. 63, recip. Tenn. 64, 115 E. Francis Ave., Jacksonville, Alabama 36265.

Jefferson County

Abernathy, Frank, Jr., b 34, mc S. C. 65, recip. S. C. 67, 2030 Montreat Pkwy., Birmingham, Alabama 35216

TRANSFERS

Bullock County

Klingler, Harold, State Department of Health, State Office Bldg., Montgomery, Alabama from Member Montgomery County Medical Society to member Bullock County Medical Society.

Butler County

McCraw, Edward F., 300 College St., Greenville, Alabama from member Jefferson County Medical Society to member Butler County Medical Society.

Chambers County

Heard, Charles C., Rt. No. 2, Box 152, LaFayette, Alabama from member Geneva County Medical Society to member Chambers County Medical Society.

Etowah County

Azar, David, 1011 Forrest Ave., Gadsden, Alabama from member Talladega County Medical Society to member Etowah County Medical Society.

Azar, Kathryne N., 722 So. 12th St., Gadsden, Alabama from member Talladega County Medical Society to member Etowah County Medical Society.

Jackson County

Elmore, Gary S., Box C-5, Bridgeport, Alabama from member Clarke County Medical Society to member Jackson County Medical Society.

Jefferson County

Scruggs, Thomas Murphy, 1615 No. 25th. St., Birmingham, Alabama from Marion County Medical Society to member Jefferson County Medical Society.

White, Roy S., Suite 104, Prof. Office Bldg., 800 Montclair Rd., Birmingham, Alabama from member Tuscaloosa County Medical Society to member Jefferson County Medical Society

Tuscaloosa County

Snoddy, William T., Jr., Univ. of Alabama Student Health Center, University, Alabama from members Walker County Medical Society to Member Tuscaloosa County Medical Society

Yeargan, Wilfred W., 914 5th Ave., Tuscaloosa, Alabama from member Jefferson County Medical Society to Tuscaloosa County Medical Society.

REMOVE MEMBERS

Chambers County

McMurrain, K. D., Jr., West Point, Georgia
Moved Cincinnati, Ohio

Chilton County

Dumas, Harold, Clanton, Alabama
Moved Memphis, Tenn.

Colbert County

Lamberth, James S., Cherokee, Alabama
Moved, Unknown

Covington County

Williamson, Paul S., Andalusia, Alabama
Moved Summitt, Miss.

Jefferson County

Dodge, Harold T., Birmingham, Alabama
Moved Seattle, Wash.

Edwards, Sterling, III, Birmingham, Alabama
Moved Albuquerque, New Mexico

Foster, Glenn L., Birmingham, Alabama
Moved California

Jumer, M. Mary, Birmingham, Alabama
Moved Glen Ellyn, Ill.

Leach, William B., Birmingham, Alabama
Moved Wilmington, N.C.

Riederer, Robert Edward, Birmingham, Ala.
Moved Sterling, Kansas

Woodard, John, Birmingham, Alabama
Moved Atlanta, Georgia

Madison County

Jordan, Bertis B., Huntsville, Alabama
Moved Pensacola, Florida

Treadwell, T. W., Jr., Huntsville, Alabama
Moved Jackson, Mississippi

Mobile County

Swan, John L., Mobile, Alabama
Moved Louisiana

Thames, Arnold F., Mobile, Alabama
Moved California

Montgomery County

Long, Irl R., Montgomery, Alabama
Transfer Non Member

Collins, Dierdre S., Montgomery, Alabama
Moved Panorama, California

Russell County

Corder, Vernon W., Phenix City, Alabama
Moved Atlanta, Georgia

Talladega County

DeRuiter, J. W., Talladega, Alabama
Moved Winter Haven, Fla.

Tuscaloosa County

Partlow, R. C., Jr., Tuscaloosa, Alabama
Moved Boston, Mass.

Turpin, Delilah, Tuscaloosa, Alabama
Moved Clemson, N. C.

(Continued on Page 1037)

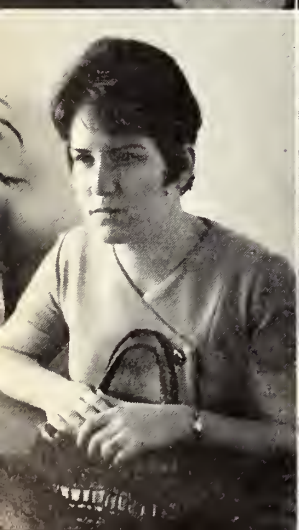


Not just the tough cases...

Depend on Candeptin® (candicidin) as the agent of first choice in all Candida cases.










Symptoms subside in 48 to 72 hours!

Itching, burning, discharge, and malodor disappear rapidly... patient's embarrassment, too.

Avoids the disappointment of "the cure that didn't take."

CANDEPTIN is "cidal" as well as "static," it is 100 times more potent *in vitro* than nystatin,[2] and it has achieved culture-confirmed cure rates of 90% and more[3] (even in notoriously difficult-to-treat pregnant patients)![1,3,4]

And two weeks does it.

Usually, CANDEPTIN cures in a single 14-day course of therapy.[3]

the fortnight fungicide

Candeptin®

candicidin

Vaginal Tablets/Ointment

Formula: CANDEPTIN Vaginal Ointment contains a dispersion of candicidin powder equivalent to 0.6 mg. per gm. or 0.06% candicidin activity in U.S.P. petrolatum. 3 mg. of candicidin is contained in 5 gm. of ointment or one applicatorful. CANDEPTIN Vaginal Tablets contain candicidin powder equivalent to 3 mg. (0.3%) candicidin activity dispersed in starch, lactose and magnesium stearate.

Indications: Vaginal moniliasis due to *Candida albicans* and other Candida species.

Contraindications: Patient sensitivity to any of the components. During pregnancy manual tablet insertion may be preferred since the use of the ointment applicator or tablet inserter may be contraindicated.

Caution: Clinical reports of sensitization or temporary irritation with CANDEPTIN Vaginal Ointment or Vaginal Tablets have been extremely rare. To avoid reinfection, it is recommended that the patient refrain from sexual intercourse during treatment or the husband wear a condom.

Dosage: One vaginal applicatorful of CANDEPTIN Ointment or one Vaginal Tablet is inserted high in the vagina, twice a day, in the morning and at bedtime, for 14 days. Treatment may be repeated if symptoms persist or reappear.

Dosage forms: CANDEPTIN Vaginal Ointment is supplied in 75 gm. tubes with applicator (14-day regimen requires 2 tubes). CANDEPTIN Vaginal Tablets are packaged in boxes of 28, in foil, with inserter—enough for a full course of treatment. Store under refrigeration.

Federal law prohibits dispensing without prescription. CANDEPTIN is a registered trade-mark of Julius Schmid, Inc.

References: 1. Olsen, J. R.: Journal-Lancet 85:287 (July) 1965. 2. Lechevalier, H.: Antibiotics Annual 1959-1960, New York, Antibiotica, Inc., 1960, pp. 614-618. 3. Giorlando, S. W., Torres, J. F., and Muscillo, G.: Am. J. Obst. & Gynec. *90*:370 (Oct. 1) 1964. 4. Friedel, H. J.: Maryland M. J. *15*:36 (Feb.) 1966.

Julius Schmid Pharmaceuticals
423 West 55th Street
New York, N.Y. 10019

AROUND THE STATE

(Continued from Page 1035)

CHANGES OF ADDRESS

Calhoun County

Gibbins, George W., present Anniston, to 1029 Christine Ave., Anniston, Alabama 36201

Reaves, John E., present Anniston, to 1029 Christine Ave., Anniston, Alabama 36201

Simmons, Robert C., Jr., present Anniston, to 5716 Pelham Rd., Anniston, Alabama 36201

Stallworth, Nicholas R., present Jacksonville, to 822 Leighton Ave., Anniston, Alabama 36201

Strange, Charles E., present Jacksonville, to 115 E. Francis Ave., Jacksonville, Alabama 36265

Chambers County

Heard, Charles C., present Geneva to Rt. No. 2, Box 152, Lafayette, Alabama 36862

Powell, F. Marvin, present West Point, Georgia to 2209 32nd Place, Shawmut, Alabama 36876

Clarke County

Elmore, Gary S., present to Gen. Del., Stevenson, Alabama 35772

Colbert County

Wayland, James L., present Sheffield to 500 N. Montgomery Ave., Sheffield, Alabama 35660

Conecuh County

Yeargan, R. L., Jr., present Evergreen to 109 S. Main St., Evergreen, Alabama 36401

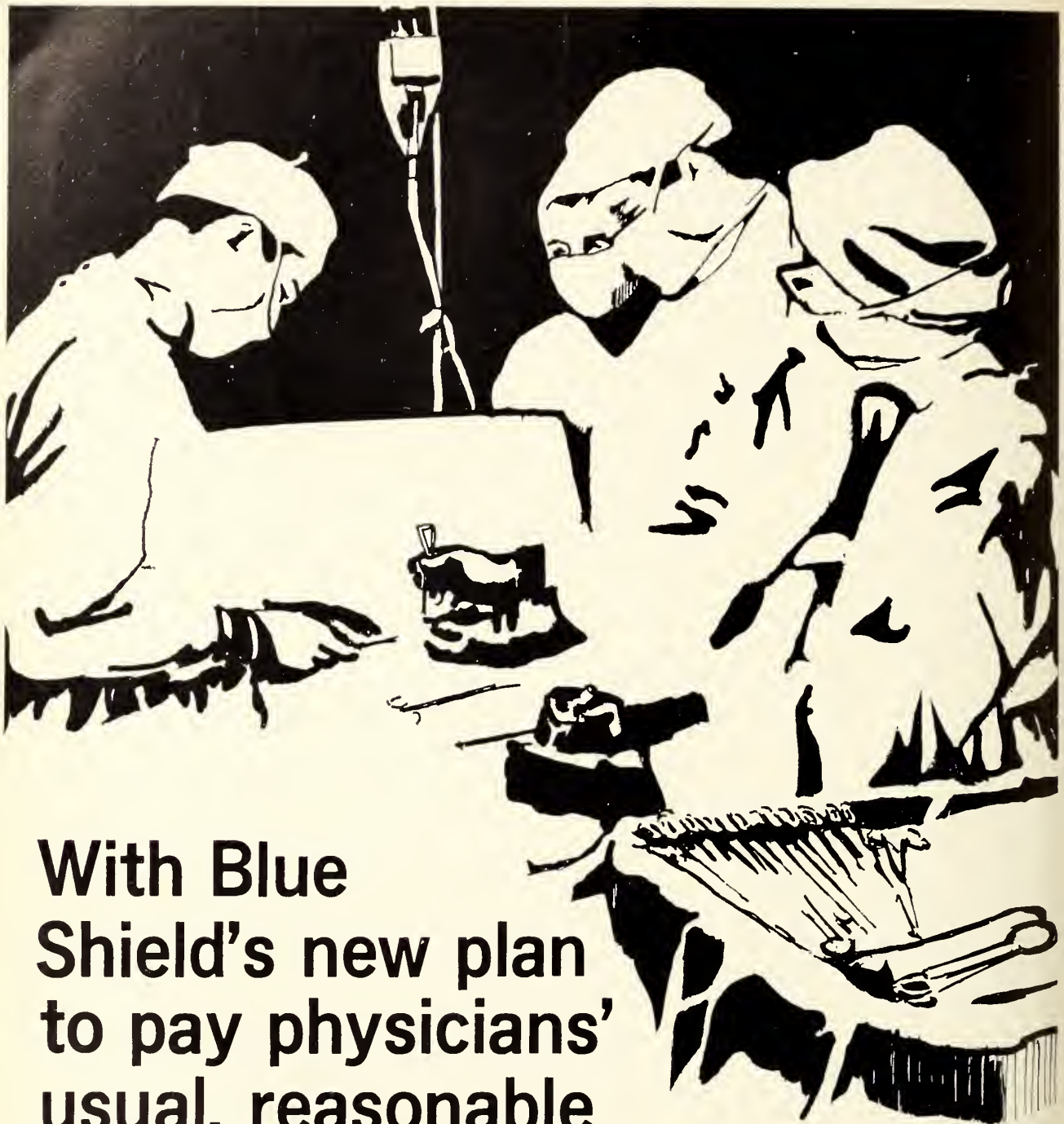
Dallas County

Angle, David L., present Selma to P. O. Box 579, 313 Sherwood Dr., Selma, Alabama 36701

Cox, Clyde B., Jr., present Selma to 611 Broad St., Selma, Alabama 36701

Downard, Joe T., present Selma to Box 557, 521 Alabama Ave., Selma, Alabama 36701

(Continued on Page 1039)



With Blue Shield's new plan to pay physicians' usual, reasonable and customary fees, your patients are far less likely to favor methods of government-controlled health care.

BLUE CROSS-BLUE SHIELD OF ALABAMA

®

(Continued from Page 1037)

Hood, William G., Jr., present Selma to Box 1369, 311 Dallas Ave., Selma, Alabama 36701

McCall, Doy L., Jr., present Selma to Box 1369, Selma, Alabama 36701

Moss, Phillip B., Jr., present Selma to Box 327, 509 Parkman Ave., Selma, Alabama 36701

Overstreet, Donald C., present Selma to Box 1127, 429 Lauderdale St., Selma, Alabama 36701

Stewart, Jonas H., Jr., present Selma to 718 Alabama Ave., Selma, Alabama 36701

Etowah County

Collier, James R., present Gadsden to P. O. Box 555, Gadsden, Alabama 35902

Houston County

Brice, Donald W., present Dothan to 509 W. Main St., Dothan, Alabama 36301

Johnson, George E., present Dothan to 406 Washington, West, Dothan, Alabama 36301

Jones, James, Jr., present Dothan to 509 W. Main St., Dothan, Alabama 36301

Turner, Wilson H., present Dothan to P. O. Box 1388, 307 W. Woodland, Dothan, Alabama 36301

Jefferson County

Abele, Henry B., present Birmingham, Alabama to 401 Lowell Dr., Huntsville, Ala. 35801

Accinno, Mario A., present Birmingham, to 2029 Warrior Rd., Birmingham, Alabama 35208

Akin, John M., Jr., present Birmingham to 800 Montclair Rd., Birmingham, Alabama 35213

Armour, William S., present Birmingham, to 2952 Pump Hill Rd., Birmingham, Alabama 35243

Bean, Stewart K., present Birmingham, to 5139 So. Main St., Graysville, Alabama 35073

Bell, Palmer H., present Bessemer to 473 Shades Crest Rd., Birmingham, Alabama 35216

Boname, John R., present Birmingham to 800 Montclair Rd., Birmingham, Alabama 35213

Briggs, Dick D., present Birmingham to 1529 No. 25th Street, Birmingham, Alabama 35204

Benton, John W., Jr., present Birmingham, to 1601 6th Ave., So., Birmingham, Alabama 35233

Caldwell, Tom O., present Birmingham, to 800 Montclair Rd., Birmingham, Alabama 35213

Carmichael, Josiah C., present Birmingham to 801 Princeton Ave., Suite 201, Birmingham, Alabama 35211

Carraway, Charles A., present Birmingham, to 1529 No. 25th St., Birmingham, Alabama 35204

Carson, Arthur J., present Birmingham, to 801 Princeton Ave., S. W., Birmingham, Alabama 35211

Casten, Gus G., present Birmingham to 1211 So. 27th St., Birmingham, Alabama 35205

Cobbs, Charles G., present Birmingham to 3840 Spring Valley Rd., Birmingham, Alabama 35243

Cothran, Robert M., present Birmingham to 315 Medical Arts Bldg., Birmingham, Alabama 35205

Davis, Sarah F., present Birmingham to 1919 7th Ave., So., Birmingham, Alabama 35233

Dixon, Joseph M., present Birmingham to 101 Medical Arts Bldg., Birmingham, Alabama 35205

Farmer, Harry R., present Fairfield to 118 8th St., So., Columbus, Mississippi 39701

Gibbs, Sidney R., present Bessemer to Lloyd Noland Hospital, Fairfield, Alabama 35064

Glover, Lester B., present Birmingham to 1919 7th Ave., So., Birmingham, Alabama 35233

Goldstein, Ben, present Birmingham, to 1630 So. 11th Ave., Birmingham, Alabama 35205

Gonzalez-Rodriguez, Juan, present Birmingham, to P. O. Box 3387A, 1500 6th Ave., So., Birmingham, Alabama 35233

Hammack, William J., present Birmingham to 700 So. 19th St., Birmingham, Alabama 35233

Harrison, Tinsley, present Birmingham to 3220 Country Club Rd., Birmingham, Alabama 35213

Henley, Felix T., present Birmingham to 800 Montclair Rd., Birmingham, Alabama 35213

Jordan, John S., Jr., present Birmingham to 800 Montclair Rd., Birmingham, Alabama 35213

Langdon, Harold R., present Birmingham to Anniston Army Depot, Anniston, Alabama 36201

McAuley, Malcolm, present Birmingham to 1919 7th Ave. So., Birmingham, Alabama 35233

Mullins, C. E., present Graysville to 507 Roselle Lane, Birmingham, Alabama 35210

Oliver, Ernest B., present Birmingham, to 801 Princeton Ave., Suite 201, Birmingham, Alabama 35211

Pardue, William O., Jr., present Birmingham to Lloyd Noland Hospital, Fairfield, Alabama 35064

Parsons, Joseph L., present Birmingham to 5 Rockledge Rd., Birmingham, Alabama 35213

Pitts, William R., present Pleasant Grove to Woodward Dispensary, Woodward, Alabama 35189

Ronderos, Alvaro D., present Birmingham to 3569 River Bend Rd., Birmingham, Alabama 35223

Russell, John W. present Birmingham to 412 No. 4th Ave., Bessemer, Alabama 35020

Schneider, C. F., present Birmingham to P. O. Box 3387 A, 1500 6th Ave., So., Birmingham, Alabama 35205

Scofield, George F., present Birmingham to 1529 No. 25th St., Birmingham, Alabama 35234

Seibold, James L., present Birmingham to 2315 So. 20th St., Birmingham, Alabama 35209

Stewart, Vera B., present Birmingham to P. O. Box 6191, 900 S. 19th St., Birmingham, Alabama 35209

Warrick, William D., present Birmingham to 800 Montclair Rd., Birmingham, Alabama 35213

Watson, Horace E., present Birmingham to 801 Princeton Ave., Birmingham, Alabama 35211

West, Otus T., present Birmingham, to 901 So. 15th St., Suite J., Birmingham, Alabama 35205

Whitehead, John S., present Birmingham to 800 Montclair Rd., Birmingham, Alabama 35213

Wilhite, Wilson C., Jr., present Birmingham to P. O. Box 734, Birmingham, Alabama 35201

Wilson, Ollie E., present Birmingham, Alabama to 1621 28th St., W., Birmingham, Alabama 35218

Lauderdale County

Fraser, Lewis E., present Florence to P. O. Box 798, 416 Seminary, Florence, Alabama 35630

Herndon, Henry V., present Florence to P. O. Box 798, 416 Seminary, Florence, Alabama 35630

Melson, Gilbert R., present Florence to P. O. Box 126, 102 Pine St., So., Florence, Alabama 35630

Middleton, James G., present Florence to P. O. Box 798, 416 Seminary, Florence, Alabama 35630

Norvell, Lester R., present Florence to P. O. Box 798, 416 Seminary, Florence, Alabama 35630

Price, Lance C., present Florence to P. O. Box 798, 416 Seminary, Florence, Alabama 35630

Roberts, Shaler S., present Florence to P. O. Box 798, 416 Seminary, Florence, Alabama 35630

Roberts, Shaler S., Jr., present Florence to P. O. Box 798, 416 Seminary, Florence, Alabama 35630

Simpson, Harry M., Jr., present Florence to P. O. Box 798, 416 Seminary, Florence, Alabama 35630

Simpson, Wyatt C., present Florence to P. O. Box 798, 416 Seminary, Florence, Alabama 35630

Spence, Ranel B., present Florence to P. O. Box 798, 416 Seminary, Florence, Alabama 35630

Madison County

Anderson, Henry L., Jr., present Huntsville to 410 Lowell Drive, Huntsville, Alabama 35801

Brown, John A., Jr., present Huntsville, to 930 Franklin St., Huntsville, Alabama 35801

Drake, Harold F., present Huntsville to 2105 Holmes Ave., W., Huntsville, Alabama 35801

Hyatt, Arthur J., present Huntsville to 205 St. Clair Ave., Huntsville, Alabama 35801

Knox, George E., present Huntsville to 930 Franklin St., Huntsville, Alabama 35801

McElroy, Andrew H., Jr., present Huntsville to 205 St. Clair Ave., Huntsville, Alabama 35801

Mitchell, Robert B., present Huntsville to 201 Longwood St., Huntsville, Alabama 35801

Moore, Billy Sam, present Huntsville, to 805 Madison St., Huntsville, Alabama 35801

Rogers, James H., present Huntsville to 410 Lowell Drive, Huntsville, Alabama 35801

Stewart, Robert E., present Huntsville to 726 Madison St., Huntsville, Alabama 35801

Wheeler, Don A., present Huntsville, to 205 St. Claire Ave., Huntsville, Alabama 35801

Whitehead, Leslie E., present Huntsville to 205 St. Clair Ave., Huntsville, Alabama 35801

Mobile County

Allgood, Homer, present Mobile to 61 Bit & Spur Rd., Mobile, Alabama 36608

Bedsole, Donald O., present Saraland to 1803 C. No. Wilson Ave., Mobile, Alabama 36604

Boger, Robert M., present Mobile to 1367 Government St., Mobile, Alabama 36604

Carlin, John T., Jr., present Mobile to P. O. Box 995, 1700 Center St., Mobile, Alabama 36604

Cobb, Jeptha B., present Mobile to 3977 Burma Rd., Mobile, Alabama 36604

Coleman, Jack T., present Mobile to 231 Shelton Beach Rd., Mobile, Alabama 36613

deJuan, Eugenio, present Mobile to 1563 Springhill Ave., Mobile, Alabama 36604

Dodson, James H., present Mobile, to 2308 Ashland Place Ave., Mobile, Alabama 36607

Eggers, Earl M., present Mobile, to P. O. Box 4481, Mobile, Alabama 36604

Eskridge, Marshall, present Mobile to Mobile Infirmary, P. O. Box 7544, Mobile, Alabama 36607

Eubanks, James R., present Mobile, to 1564 Center St., Mobile, Alabama 36604

Greene, John H., present Mobile to 231 Shelton Beach Rd., Mobile, Alabama 36604

Johnson, Gayle T., present Mobile to 1367 Springhill Ave., Mobile, Alabama 36604

Lane, Martin L., present Mobile to 1564 Center St., Mobile, Alabama 36604

Langley, John O., present Mobile to 1720 Center St., Mobile, Alabama 36604

LeFlore, Walker B., present Mobile to 227 Lexington Ave., Mobile, Alabama 36603

McGee, Lawrence S., Jr., present Mobile to 1714 Center St., Mobile, Alabama 36604

Murphy, Samuel S., Jr., present Mobile to 201 Milner Bldg., Mobile, Alabama 36604

Morton, Edwin D., present Mobile to Office Park Bldg., Mobile, Alabama 36604

Pringle, B. Clifford, Jr., present Mobile to 1919 7th Ave., So., Birmingham, Alabama 35233

Semon, John E., present Mobile to 1653 Springhill Ave., Mobile, Alabama 36604

Speir, Betty R., present Mobile to 1367 Government St., Suite II, Mobile, Alabama 36604

Walker, Rhett P., present Mobile to 168 Louiselle St., Mobile, Alabama 36607

Wallace, Gerald L., present Satsuma to Hwy. 43, Satsuma, Alabama 36572

Montgomery County

Brock, William M., present Montgomery to 2119 E. So. Blvd., Montgomery, Alabama 36111

Lightfoot, Philip M., Jr., present Montgomery to 1709 Pine St., Montgomery, Alabama 36106

Palmer, Glenn F., present Montgomery to 1766 Pine St., Montgomery, Alabama 36106

Peters, George S., present Montgomery to 52 Clayton St., Montgomery, Alabama 36104

Stough, Austin R., present Montgomery to 713 Sweeten Creek Rd., Montgomery, Alabama 36109

Tyler, Thomas B., present Montgomery to 1762 Pine St., Montgomery, Alabama 36106

Morgan County

Kilpatrick, Troy F., present Decatur to Courtland Clinic, Courtland, Alabama 35618

Tuscaloosa County

Davis, Luther, Jr., present Tuscaloosa to P. O. Box 2389, Student Health Center, Tuscaloosa, Alabama 35401

Davis, Samuel D., Jr., present Northport to 2804 19th Ave., Northport, Alabama 35476

NEW TELEPHONE NUMBERS

Alexander, S. B., Tuscaloosa	348-6262
Allgood, Homer, Mobile	342-7330
Akin, John M., Jr., Jefferson	595-4697
Arrington, Thomas, Madison	539-5179
Batson, Paul J., Jr., Etowah	546-9245
Baxley, W. A., Jefferson	934-5378
Beck, Ronald V., Russell	298-0671
Benton, John W., Jefferson	934-4974
Blankenship, B. E., Jefferson	933-2078
Brahen, Louis, Tuscaloosa	553-5288
Bright, William Allen, Tuscaloosa	752-1591
Bryant, Kirby K., Jr., Calhoun	236-6607
Bush, Stephen T., Jefferson	322-0453
Caldwell, Tom O., Jefferson	591-2393
Campbell, John H., Etowah	547-6331
Campbell, R. E., Colbert	383-2821
Carmichael, Josiah C., Jefferson	786-3439
Carmichael, Robert G., Jefferson	879-0920
Clark, Charles F., Calhoun	237-8933
Cobbs, Beverly, Montgomery	262-4279
Cooner, W. H., Mobile	433-6595
Coyle, Daniel J., Jr., Jefferson	328-7065
Daniel, W. A., Jr., Jefferson	323-8901
Elliott, Mary C., Calhoun	237-7577
Eskridge, Marshall, Mobile	433-3511
Ferlisi, Joseph A., Coffee	347-2693
Finney, J. O., Jefferson	934-5187
Friedman, Benjamin, Jefferson	533-0946
Gibbins, G. W., Calhoun	237-0371
Gray, Gene W., Jefferson	328-6337
Gully, V. S., Butler	459-2320

Gumbs, O. S. Mobile	432-5836
Haigeorgiou, George P., Jefferson	324-0378
Hardy, Gordon B., Jefferson	967-4631
Holley, Hilmon D., Etowah	546-4611
Hurd, Thomas, Lee	745-6447
Johnson, Bruce, Jefferson	251-9106
Johnson, George E., Houston	792-5179
Jordan, John S., Jr., Jefferson	595-4697
LeFlore, W. B., Mobile	433-5506
LeMay, Bobby B., Jefferson	328-8996
McAuley, Malcolm, Jefferson	934-4011
McCown, J. D., Lauderdale	383-7141
Mitchell, W. L., Coffee	347-2233
Monzingo, G. F., Coffee	347-5435
Mosley, Everett C., Madison	539-4992
Motte, Elmer, Jefferson	631-3118
Nieman, Kurt M. W., Jefferson	967-5950
Oliver, Ernest B.	786-3439
Phillips, Edwin J., Morgan	355-3311
Pieroni, Daniel, Colbert	381-3180
Powell, F. M., Chambers	768-2185
Rutherford, Charles L., Jr., Jefferson	879-7571
Scrivner, J. D., Fayette	689-4534
Scruggs, Thomas M., Jefferson	871-1350
Speir, Betty, Mobile	433-1563
Speir, H. P., Butler	382-5121
Speir, R. C., Jefferson	871-3294
Stallworth, N. R., Calhoun	237-8004
Thomas, Edward L., Jefferson	786-8788
Warren, W. S., Etowah	547-8941
Wayland, J. L., Colbert	383-0251
West, E. A., Marion	935-3517
Whites, Jack C., Jefferson	252-9931
Wilhite, W. C., Jr., Jefferson	251-4231
Wiltsie, Robert E., Jefferson	785-2121
Windham, Andrew A., Franklin	332-2414
Wood, J. E., Winston	486-5255
Yeargan, R. L., Jr., Conecuh	578-2662
Azar, David, Etowah	547-8751
Azar, Kathryne, Etowah	547-9760

DEATHS

Chambers County

Cowles, William L., West Point, Georgia, deceased December 16, 1969.

Jefferson County

Colquitt, Charles J., Bessemer, Alabama, deceased January 20, 1970.

Howe, Charles D., Birmingham, Alabama, deceased February 22, 1970.

Lamar County

Roberts, John Monroe, Vernon, Alabama, deceased, date unknown.

Marshall County

Martin, Thomas E., Guntersville, Alabama, deceased April, 1969.

St. Clair County

Gartrell, Luther S., Ashville, Alabama, deceased March 22, 1970.

DOCTORS
Who Play With Fire
(Their Favorite Recipes)

VENISON STEAK:

Cut every possible piece of fat from your venison tenderloin. Put in dutch oven and marinate two to three hours in wine vinegar, lemon juice, worcestershire sauce, and slices of white onions . . .

After cleaning oven thoroughly, brown two thick handcut strips of bacon, leaving grease in bottom of oven. Place steaks, marinated ingredients, and one stick of butter or margerine, in oven, with salt and pepper to taste. Cook until meat is tender.

Serve with french bread and garlic butter, and try not to overeat!

—Robert Parker, M.D.
Montgomery

in active stages of moderate to severe rheumatoid arthritis,

What more can you

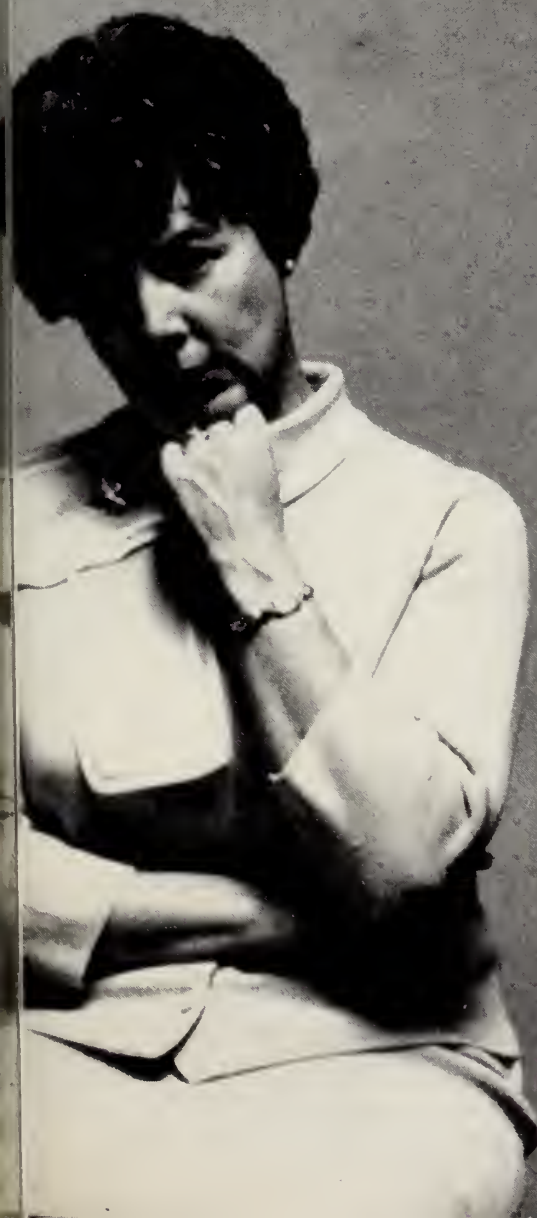
after you've tried



rheumatoid spondylitis, and osteoarthritis of the hip

do for these patients?

salicylates and rest



INDOCIN®

(INDOMETHACIN | MSD)

helps relieve pain, fever, swelling, and tenderness

Please see new prescribing information on following page.



REVISED PRESCRIBING INFORMATION

IMPORTANT NOTE. INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended under Indications. The drug should not be prescribed for children because safe conditions for use have not been established.

General Adverse Effects: Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg/day, without corresponding clinical benefits; and 2) careful instructions to, and observations of, the individual patients are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

Indications: Symptomatic relief of adult rheumatoid and degenerative joint disease unresponsive to adequate trial of salicylates and other measures of established value, such as appropriate rest. Has been found effective in active stages of: 1) moderate to severe rheumatoid arthritis including acute flares of chronic disease, 2) moderate to severe rheumatoid (ankylosing) spondylitis, and 3) moderate to severe degenerative joint disease of the hip (osteoarthritis of the hip). Has been found effective in relieving pain and reducing fever, swelling, and tenderness in acute gouty arthritis in selected patients. May enable reduction of steroid dosage in patients receiving steroids for the more severe forms of rheumatoid arthritis; in such instances the steroid dosage should be reduced slowly and the patients followed very closely for any possible adverse effects.

Contraindications: Children 14 years of age and under, pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin and indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.
Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.
Central Nervous System Effects: INDOCIN (Indomethacin, MSD) may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.), rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis, which may persist after the cessation of the drug, nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.
Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.
Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.
Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.
Hypersensitivity Reactions: Acute respiratory distress, including dyspnea and asthma; angiitis; pruritus; urticaria; angioedema; skin rashes.
Ear Reactions: Hearing disturbances, deafness, tinnitus.
Central Nervous System Reactions: Psychotic episodes, depersonalization, depression, coma, convulsions, peripheral neuropathy, drowsiness, mental confusion, lightheadedness, dizziness, headache.
Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.
Dermatologic Reactions: Loss of hair, erythema nodosum.
Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

Supplied: Capsules containing 25 mg indomethacin each, in bottles of 100 and 1000; capsules containing 50 mg indomethacin each, in bottles of 100.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

MERCK SHARP & DOHME | **where today's theory is tomorrow's therapy**
Division of Merck & Co. Inc. West Point Pa 19486

Hobbies To Fill A Doctor's Leisure

While His WAMASA Partner Relaxes With a Good Book

"Cooks are gentlemen!" Robert Burton proclaimed some 350 years ago in his *Anatomy of Melancholy.* Were he living today, he might have added: "And some of the best cooks are doctors!"

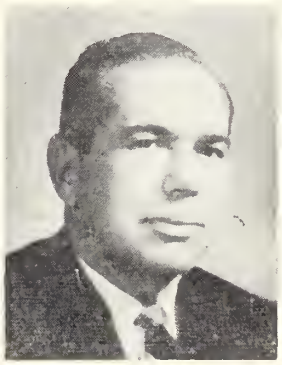
A gentleman from the Deep South (from Sunflower County, Mississippi, to be exact), a friend of some years' standing who as Food Editor of The New York Times is fast becoming one of the world's foremost authorities on kitchen art, has bylined a book that suggested my peek at physicians standing across the kitchen stove or the cookout grill.

It is not Craig Claiborne's first book by any means, but rather his fifth. Nine years ago came his *The New York Times Cook Book,* followed by three other volumes for sophisticates. And now he has returned to earth with his *Kitchen Primer,* a 270-page book published by Alfred Knopf priced at $6.95, a clear and distinctive guide book, a basic cookbook illustrated by Tom Funk "that leads the beginner from here to there in the kitchen, with pictures to show techniques and equipment and having recipes throughout that put into practice the fundamentals of good cooking."

"Is Your Hobby Cooking?" asked a display ad on the back page of *The Alabama M. D.* of March 12th. Some of those doctors who responded are:

* * *

Jack Hyman, M. D., a native Floridian now specializing in Urology in Mobile, finds his interest revolving around seafood, sauces and salads. For nearly two decades he has collected and reproduced favorite recipes from some of the most famous restaurants in the nation.



DR. HYMAN

Born in Tampa April 3, 1917, just 24 hours after President Wilson asked the Congress to declare war on Germany, Dr. Hyman's higher education and degrees were obtained from the University of Florida and Tulane. He is married to the former Frances Levy of New Orleans, and there are four children: Philip, 23; Robert, 21; Cathy, 16; and Ellen, 12.

Dr. Hyman's modification of Antoine's recipe for Oyster Foch will be used in a future issue of The Journal of the Medical Association of the State of Alabama.

* * *

Marcus Dee Moody, M. D., in general practice in his native Childersburg, finds the grilling of steaks and the barbecuing of ribs to his special liking. It all began some 20 years ago with basic recipes for outdoor cooking, but since then to the tastebud-titillating secrets of the gourmet.



DR. MOODY

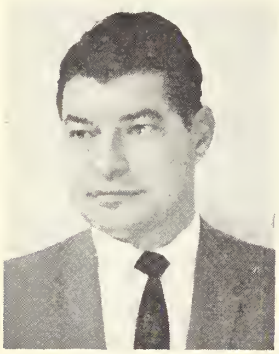
Mrs. Moody is the former Henrietta White of Charleston, S. C. and they have three sons, two mar-

ried and still students at the University of Alabama, one in high school; and two grandchildren.

Dr. Moody was born in Childersburg Oct. 17, 1920. His degrees, including his M.D. are from the University of South Carolina.

* * *

John Robert Morris, M. D., a native of Ohio who practices his specialty, Urology, in Anniston, is another Alabama doctor whose cooking enthusiasm centers on meats. His recipe for barbecuing marinated ham steaks will be featured in the months ahead.



DR. MORRIS

Dr. Morris shares a birthday with Dr. Parker, born May 16, 1924, in Youngstown, Ohio, the son of a dentist. His baccalaureate and M. D. were obtained, respectively, from Ohio and Duke. His Navy tour of duty was served largely in Key West. Mrs. Morris is a North Carolinian, the former Nell Poole, whom he met at Duke, and they have one daughter, Janet, who will attend the University of Alabama next year.

Dr. Morris's interest in cooking developed as a child, and cakes were his first product of the kitchen.

After his 60th year a man is more surprised to find himself right about something than he was at 20 to find he was wrong about something.

—Strickland Gillilan

Lots of folks wouldn't look as old as they do if they didn't act as young as they do.

—Joe Digiovanni

Robert Parker, M. D., Montgomery pediatrician—chose cooking as the lesser of two evils. On a hunting trip in the wilds of Wyoming, with the thermometer frigidly below zero, and the hunting party hungry, it developed that only one huntsman knew nothing at all about cooking. Dr. Parker was he—and he was allowed the privilege of washing dishes!



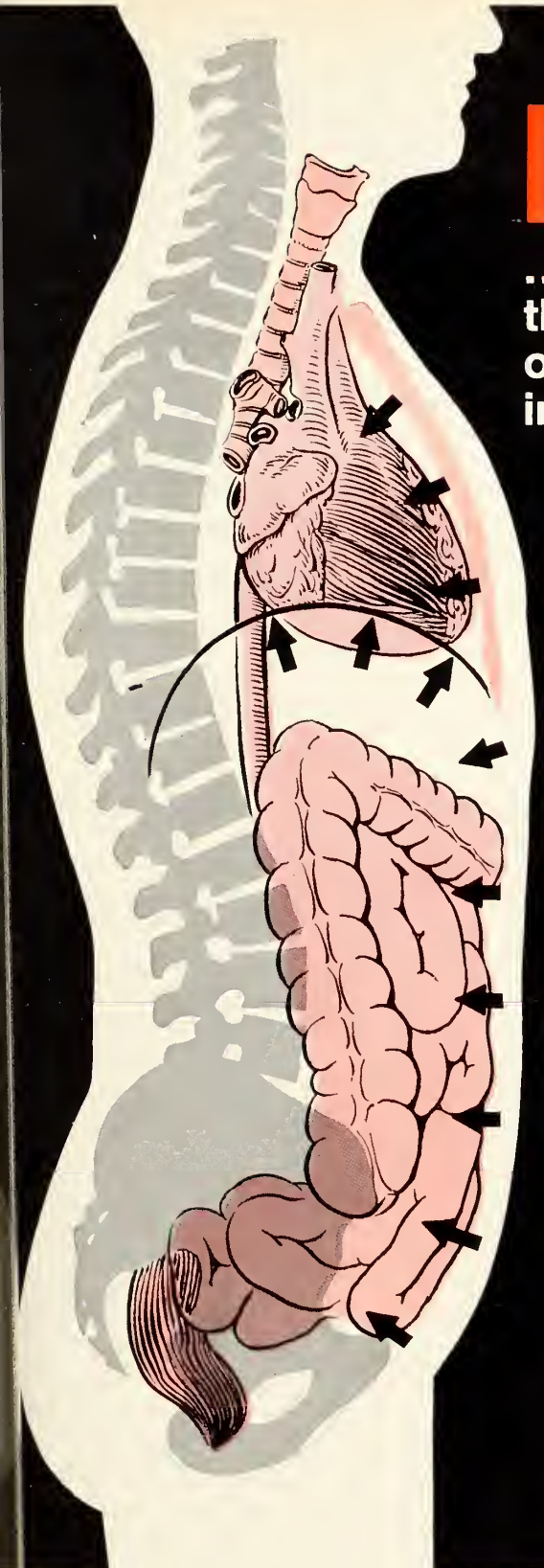
DR. PARKER

Today, cooking is a hobby pursued with great enthusiasm by this same Dr. Robert Parker. And perhaps there is significance in the fact that his specialty-of-the-house is a principal product of the hunt—venison. (His recipe for venison appears elsewhere in this issue of the Journal to launch a tersely-told series to which doctors are invited to contribute).

Dr. Parker celebrates a birthday the middle of this month, born in Coweta County, Georgia, May 16, 1902. From Newnan, Ga., High School he went to Vanderbilt for his B. A. and M. D. degrees. Mrs. Parker is the former Ruth Hackett, whose father was the first president of the Montgomery Rotary Club. And there are two children: Alice, a Mary Baldwin graduate, now Mrs. Charles G. Berry, and Robert Hackett Parker, an Auburn graduate in Veterinary Medicine, who went through basic Marine training on Parris Island before transferring to the Air Force, a captain presently serving on Okinawa.

Dr. and Mrs. Parker are flying the Pacific late this spring for a visit with their son on the former Japanese island. They also plan to see Taiwan where they will see the monument in front of the Presidential Palace raised to the memory of a onetime Alabamian:—the late Lt. Gen. Claire Lee Chennault.

(Continued on Page 1050)



DOXIDAN®

...to reduce the hemodynamic "bind" of constipation in congestive heart failure

Constipation in the chronic heart failure patient carries with it the ever-present threat of acute cardiac decompensation while straining at stool. In the already weakened, distended heart, a sudden influx of blood on termination of the Valsalva maneuver is considered to be the mechanism of some of the deaths occurring in these cardiac patients during straining efforts.*



Doxidan is a gentle laxative designed to free your patient from the hemodynamic consequences of straining at stool. With a fecal softening agent to keep the stool soft and easy to evacuate, and with just enough peristaltic stimulation to urge the sluggish bowel, Doxidan reduces the hemodynamic "bind" of constipation.

Composition: Each capsule contains 50 mg. danthron N.F. and 60 mg. dioctyl calcium sulfosuccinate.

Dosage: Adults and children over 12—one or two capsules daily. Children 6 to 12—one capsule daily. Give at bedtime for two or three days or until bowel movements are normal.

Supplied: Bottles of 30, 100 (FSN 6505-074-3169) and 1000 (FSN 6505-890-1247).

B[illegible], C. H. and Taylor, N. B.: *The Physiological Basis of Medical Practice*, 7th edition, Williams and Wilkins, Baltimore, 1961, p. 480.

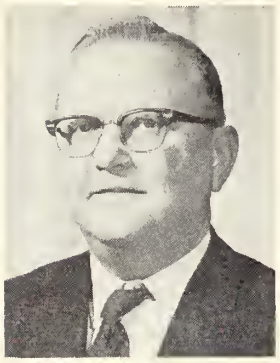
DOXIDAN®

HOECHST
PHARMACEUTICAL CO.
Div. American Hoechst Corp.
Cincinnati, Ohio 45229 U.S.A.

C-124

(Continued from Page 1048)

And finally, for this one-of-a-series on "Hobbies to Fill a Doctor's Leisure," there is William Lamar Smith, M. D., a native of Wetumpka, with degrees in psychology, philosophy and medicine from Tulane.



DR. SMITH

Commissioned in the infantry in 1942, his active duty was deferred two years while he completed his medical education. Following military service from 1944 to 1946, he went into general practice in Montgomery in August, 1946.

Dr. Smith is married to the former Janie Sansing of Newton, Miss. And there are four children: Janie Elizabeth (known to her intimates as Betsy), now Mrs. Winston Pirtle; Sansing, now Mrs. Terry McPherson, who graduates this year with a Ph. D. from Duke; William Lamar Smith, Jr., just returned from Army service in Vietnam; and George B. Smith II.

William Lamar Smith was born in Wetumpka Nov. 1, 1917, and by the age of five was already experimenting in the kitchen of his grandfather William L. Lancaster's home. This grandfather, Democratic leader, onetime State Senator, State Treasurer, and Secretary of State, founder and president of the Bank of Wetumpka, a past president of the Alabama Bankers Association, was celebrated for the gourmet dinners that were served in his home. It was natural that his grandson should develop an early interest in food and its preparation.

Today Dr. Smith delights in a variety of dishes—molded cold dishes, fruits, meats, duck, dove, turkey and quail, gumbo, turtle and other soups. Which brings him a long way from the time a five-year-old boy in the kitchen of indulgent grandparents used to mix everything that came to hand—flour, milk, nutmeg, soda, baking powder, and whatever—stir it all together, bake it in the oven, and delight in whatever came out.

To illustrate the distance he has traveled between the age of five and the age of 52, a magazine article about his cooking, published nine years ago, is captioned as follows:

Canapes
Oysters Casino a la Luchow
Smothered Doves
Wild Rice
Broccoli with Almonds
Salad
Caramel Custard
Coffee

And that is quite a dinner for a busy doctor to tackle, isn't it?

—W. J. M., Jr.

WHO WORKS

"The population of the country is 160 million but there are 62 million over 60 years of age, leaving 98 million to do the work.

"People under 21 total 54 million, which leaves 44 million to work. There are 31 million in the federal services which leaves 13 million workers. Deduct 12,800,000 for state and city employes and that leaves 200,000 to work.

"There are 126,000 in hospitals, mental hospitals, etc., which leaves 74,000 to work, but 62,000 of these are bums and others who won't work, so that leaves but 12,000. Now it may interest you to know that there are 11,998 people in jail, so that leaves only two people to work. That's you and me, brother, and I'm getting tired of doing everything myself."

—Journal, Oklahoma State Medical Association



Health Problems in Colonial Alabama

By Milo B. Howard, Jr.

Of the two hundred years that the land called Alabama has been known to Europeans only 150 pertain to the history of the actual State of Alabama. Far more years of our history precede the founding of our nation than follow it. Those years and that history belong to the French, the Spanish, the British, and last and almost forgotten, the Indians. No doubt the advances in the past 100 to 150 years surpass all the accomplishments of those earlier inhabitants except their perseverance. Properly, the problems of the colonial period belong to the history of the great imperial powers in whose capitals, remote from hostile frontiers, the affairs of the world were settled. Yet their sway and our subsequent history was shaped by the few intrepid adventurers and desperate outcasts who braved the dangers of savages and strange diseases to found the basis for the grandeur of nations.

Health and medicine were of no little importance when a mere handful of French established themselves in the Mobile delta in 1702 or when the victorious British occupied the same area in 1763 following the French and Indian War, so disastrous to the French empire in North America. Of these home governments were aware. Throughout the colonial period the government of the colony maintained hospitals of sorts and physicians for the benefit of the colonial officials and the army which made up the most important, if not the largest part of the population. The needs of the settlers were recognized, as well, but the concept of empire and the financial means of meeting these needs did not extend to the limits of our enlightened times. For example, the drug supply for the province of Louisiana came from France and at first was dispensed through the government storehouse. Surgical instruments were available in the open market and no doubt drugs became so. Yet there was always a scarcity, the supply being arbitrarily reduced below the estimated needs of the colony. Governor de Vandreuil of Louisiana had a third interest in the trade with outposts scattered over the province and converted one room in his New Orleans home into a store where every available drug was sold. The house steward usually attend to the trade, but in his absence

Madame de Vandreuil, herself, did the selling, and a shrewd business woman she was, for so it was said, she forced merchants to buy goods from her husband at prices fixed by herself. If this seemed irregular, the governor winked at it since it brought him a handsome profit.

The local populace in the provincial towns might have the use of the government's hospitals, and the traders and soldiers on outpost duty might have the advantage of surgeons and physicians sparsely distributed over the vast area of Louisiana. But the hospitals left much to be desired. By 1734 the one in Mobile amounted to scarcely more than posts set in the ground and was in great need of being replaced. In 1763 an inventory of the Mobile Hospital showed 16 small distaff beds, 13 Spanish hair mattresses, cloth covered, two cypress cupboards and a sideboard with lock and key, 21 sheets and blankets. It was bad enough that there were at that moment 22 patients, but added to the constantly overcrowded conditions, the building lacked floors, window sashes, and chimneys. To protect the local population from charlatans and quackery, the French colonial council in the 1720's decreed that all physicians must be licensed after passing proper examinations. Priests were more numerous than physicians in the wilderness, and some had acquired medical ability. At least they could provide nursing care, but for the most part they were better at administering the last rites than avoiding them. Fortunately the new land was not unpopulated at the arrival of the Europeans, and the aborigines were not at once, or ever totally, hostile. To the mysteries of native medicines and medicine men the French were quickly introduced.

According to one French Explorer, the Indian doctors, without study, without drugs, and many times without preparation cured their patients as surely as the most skillful physicians. He was mistaken in one regard, for the Indians had acquired considerable knowledge of herbs and their specific healing qualities and this information was carefully passed on to the initiated so that something like a modern medical profession actually existed.

Antoine le Page du Pratz recorded some of the testimonials to Indian medicine and cures in his Histoire de la Louisian. On one occasion his knowledge was first-hand.

> For some days I had had a lachrymal fistula in the left eye which gave out when it was pressed a humor of very bad augury. I had it looked at by M. de S. Hilaire, a skillful surgeon, who had about twelve years at the Hotel-Dieu de Paris.
>
> He told me that it would be necessary to use fire on it; that in spite of this operation my sight would not be at all affected; that it would be as good as before, except that my eye would be bloodshot, and that if I did not have it operated on promptly the bone of the nose would decay.
>
> These statements grieved me much, I having to fear and to suffer. I was, however, resolved to go through with it, when the great Sun and his brother arrived early in the morning with a man loaded with game for me. I thanked them, and told them that they must remain and eat their part of it. They accepted the invitation.
>
> The great Sun perceived that I had an enlargement about the eye, and asked me at the same time what it was. I told him, and explained that to cure it they had told me that it was necessary to put fire to it, but that I had made up my mind to it with difficulty, because I dreaded the consequences. He answered nothing, and without forewarning me he ordered the one who had brought the game to go and bring his doctor, and to tell him that he was waiting for him at my house. On account of the diligence of the messenger and the doctor, the latter arrived an hour later. The great Sun told him

(Continued on Page 1055)

I love my family.
I adore this house.
My in-laws are great.
The neighbors are wonderful.



Indications For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications History of sensitivity to meprobamate.

Important Precautions. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient, if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated). Doses above 2400 mg./day are not recommended.

Composition. Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK™ [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

The young homemaker: her underlying anxiety and tension can surface and intensify under the continuous stress of rearing a growing family. Especially when she's confined to the home and its environs so much.

You can help her over the rough spots with reassurance and counsel. Equanil can help relieve tension, ease anxiety—with little risk of serious side effects. Time and experience will probably do the rest.

Equanil®
(meprobamate)

Wyeth Laboratories
Philadelphia, Pa.

Photo professionally posed



MAY

(Continued from Page 1052)

to look at my eye and to make an endeavor to cure me. After having examined it, the doctor said that he could cure it with simples and water. I gave him permission with so much the more pleasure and facility, as through this treatment I did not run any risk.

The same evening the doctor came with his simples pounded together and making but a single ball, which he placed in a deep basin with water, he made me bend my head over into the basin, so that my sick eye, held open, was steeped in the water. I continued doing this for eight or ten days, evening and morning, after which I was entirely cured without another operation and without it being evident there, and I never had another attack afterward.

Further extolling the skill of the native doctors, he recounted having seen them make surprising cures on several Frenchmen. Like a modern TV commercial he cited an instance where two men were apparently suffering from the same malady and being treated by the local French surgeon with the result that their heads became exceedingly swollen. One escaped from the hospital, found an Indian doctor and was cured in eight days. His comrade remained with the French doctor, where he died three days after the flight of the first, who was seen alive and prospering three years later.

Indeed, the herbs and simples with which the Indians accomplished remarkable cures were of great interest to the Europeans. Du Pratz collected more than 300 simples, labelled them with their particular qualities and the manner of using them, and shipped them to France where they were placed in a botanical garden made expressly for them. Later, the dispatch boxes from the royal governors of British West Florida frequently held more specimens for the botanical gardens at Kew than reports for his majesty's secretary of state at Whitehall.

Indeed, the French learned much about the use of native herbs and about medicinal qualities of plants long known in Europe. The balsam of the sweet gum cured wounds in two days without any evil consequences, was used for ulcers and lung ailments, relieved colic and all intestinal ills and finally "gladdened the heart." And to think, du Pratz remarked, "It serves us only for making varnish." While many herbs had very specialized healing qualities, about as many were cure-alls, and China Root for instance had the additional power of making hair grow.

In not every instance was the Indian remedy efficacious. One of the Yazoos was known to have suffered from severe pains for upwards of two years and had exhausted all of the nostrum and doctors in this tribe. Sending his daughter, who had nursed him faithfully, on an errand, no sooner had she departed than he rose, "loaded his gun with three balls, and broke his head."

Broken bones were particularly dangerous to the life of an Indian, for while the native doctors could cure flesh wounds if no vital organ was affected, they had no knowledge or skill in setting fractures. Neither did they have any use for deformed or crippled people. The treatment, if it can be called that, for a broken bone was simple: A feast was made to the unfortunate sufferer, and after some days of merrymaking he was strangled.

When the French surrendered Mobile to the British in 1763, the town had suffered not so much from the war itself as from the naval supremacy with which England had effectively cut off commerce with the Gulf of Mexico. The town had languished, the fortifications had begun to decay, for as the royal governor pointed out, in the sub-tropical climate on Mobile Bay, constant attention was necessary to keep up frame and even brick structures. Many of the French inhabitants of the new British colony departed for New Orleans or returned to France, while in Pensacola, the Spanish departed to

the man and took with them their nearest Indian neighbors. Thus, the British were cast upon their own devices for the most part in adjusting to their new environment. Unlike the French who came in small tough increasing numbers, the British at once occupied the towns on the Gulf coast with several regiments of soldiers. British soldiers in the eighteenth century were accustomed to hardship, but they were ill-prepared for the conditions which they found in Mobile, which were far more deadly than the hostile Spanish soldiers had been at their last battle at Havana. After weeks at sea the much vaunted redcoats stumbled ashore, ravaged by scurvy, and moved into the dilapidated quarters in the crowded fort.

What the British called billious, remitting, and intermitting fevers, actually yellow fever and malaria, along with jail fever, took their toll sparing neither privates nor officers, nor even the commanding general of his majesty's troops. While the death rate was high, most victims recovered and with the advent of cooler weather, the fevers subsided. In the meantime, there were frequently not enough soldiers ambulatory to mount a proper guard. The slightest improvement sent a soldier to the parapets of Ft. Charlotte and almost immediately to the hospital with a relapse. The entire medical staff in West Florida consisted of one military surgeon and six surgeon's mates, but none was sent to Mobile until a year after its occupation, and by that time it was reported that the stench which issued from the barracks and hospitals was "sufficient to knock a man down." No wonder it was said, "No person that goes to Mobile but may lay his account to have a very severe fever." By 1765 George Johnston, the British governor, concluded that "Mobile must be the most unhealthy place on the face of the earth," and warned that "persisting in quartering troops there is a kind of war against Heaven, by piling up of dead bodies."

While cooler weather was the best antidote for the remitting and intermitting fevers, it seemed to bring fluxes and dropsis with it, and typhoid and typhus were unaffected by seasons changes. The British government was concerned; Gen. Gage ordered medicines in quantities, but the number of ill and spoilage quickly negated his generosity. The arrival of Dr. John Lorimer in the colony boded improvement of conditions, but he was stationed in Pensacola and stated candidly that merely a trip to Mobile was almost enough to make him think of going north for his health.

A doctor in the colony was a man of extreme importance and it is not surprising that Lorimer was able to obtain sizeable grants of land; nor is it surprising that he dabbled in politics and gained election to the lower house of the West Florida assembly. Joining the popular party in opposition to the governor, he found himself ordered to Mobile to survey conditions there. This early medical survey was anything but encouraging. Disease, poor hospital facilities and total lack of medicine summarized the conditions he found. The garrison was so small that it could not consume a whole bullock in one day, and the meat would spoil in the heat if left overnight. As a consequence, convalescing soldiers were forced to go short on fresh meat. Civilians, financially better off than the troops, were able to purchase fresh meat daily to hasten the recovery of their strength. Living outside the close confines of the brick-walled fort, they enjoyed better ventilation and sanitation. The fort was, in fact, surrounded by a swamp, which Lorimer recommended draining. Further, he suggested building two-story barracks surrounded by galleries, and better still the establishment of a post on the east side of the bay at Montrose to which even today Mobilians repair in the summer because of the cool air.

Despairing of costly improvements, Lorimer finally concluded that troops should be sent out to the colony so as to arrive during the fall thus allowing them to recover from their voyage and become acclimated before the onset of the sickly season.

The insistence of Gen. Frederick Haldimand on ventilation, sanitation, and proper diet along with the efforts of a few hardy hospital attendants who could not escape the onerous duty, gave the suffering British the only relief they enjoyed in the plague-ridden colony. Mobile never overcame its sickly conditions, and it was indeed a "graveyard for Britons" that Gen. Bernardo de Galvez captured during the American Revolution.

The Spanish fared some better than the British, for they, like the French had a source of settlers who were accustomed, if not inured, to the climate and the dangers of the recurring epidemics of fever. No great number of troops from northern climes were stationed by the Spanish in Florida, for they were scarcely necessary. The British Colonists either changed their allegiance or left, and the nearest neighbors to the Spanish colony were the Americans, just freed from the yoke of British rule. Apparently Mobile overcame its unhealthful reputation for the town surpassed Pensacola in size at the beginning of the nineteenth century. The town was never free from the dangers of the intermitting and remitting fevers, but the Spanish soon learned that there was an even greater danger: the hearty, healthy, and land-hungry pioneers of the American frontier, who, under their idol, Andrew Jackson, seized lower Alabama in 1812, and despite plague and fever, have held it ever since.

SOURCES

Laura D. S. Harrell, "Colonial Medical Practice in British West Florida, 1763-1781," Bulletin of the History of Medicine, XLI (1967), 539-558.

Robert R. Rea, "'Graveyard for Britons,' West Florida, 1763-1781," Florida Historical Quarterly, XLVII (1969), 345-364.

Jack D. L. Holmes, "Medical Practice in the Lower Mississippi Valley during the Spanish Period, 1769-1803," Alabama Journal of Medical Sciences, I (1964), 332-338.

Dunbar Rowland and A. G. Sanders, Mississippi Provincial Archives, French Dominion, I (1729, 1740), II (1701-1729), III (1704-1743) (Jackson: Mississippi Department of Archives and History, 1927-1932).

Dunbar Rowland, Mississippi Provincial Archives, English Dominion, I (1763-66) (Nashville: Brandon Printing Co., 1911).

John R. Swanton, Early History of the Creek Indians and Their Neighbors, Bureau of American Ethnology Bulletin 73, (Washington: 1922).

John R. Swanton, Indian Tribes of the Lower Mississippi Valley and Adjacent Coast of the Gulf of Mexico, Bureau of American Ethnology Bulletin 43 (Washington: Government Printing Office, 1911).

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

Laboratory Combined Division All Reports for Period March, 1970

	No. Specimens Received
General Bacteriology	2,696
Virology	224
Parasitology	1,867
Enteric Bacteriology	336
Fluorescent Microscopy	4,289
Tuberculosis	6,032
Mycology	79
Milk and Dairy Products	5,625
Water	3,723
Sea Foods	127
Syphilis Serology	40,594
Special Serology	1,578
Metabolic Diseases	8,272
Cytology	3,342
Chemistries	204
Miscellaneous	2,510
Total Number of Specimens Received	81,498

There is only one way to coast—downhill.

—Canadian Business

A man who trims himself to suit everybody will soon whittle himself away.

—Charles Schwab

Democracy is built by those who live to give and destroyed by those who live to get.

—Swanson Newsette

Fathers and Sons in Medicine

Lexington To Montgomery—Three M. D. Generations

A young Alabama M. D., just returned from advanced studies in Vienna and about to set up practice in Montgomery, was married in Virginia in 1903 to the daughter of a Virginia M. D. who had died the year before. When the only son born of this marriage earned his M. D. it established a line of three generations of doctors.



DR. MERTINS, SR.



DR. MERTINS, JR.

The first of these three, William Scott White, was born in Lexington, Virginia in 1853. Educated in local academies, he pursued his baccalaureate at Washington and Lee, his M. D. at the University of Virginia, and interned at Bellevue Hospital, New York City.

Returning to his native Lexington in 1879, he was married to Miss Lucy Cameron, also a member of families long prominent in the Valley of Virginia, where "Stonewall" Jackson and Jubal Early were earning earthly immortality a scant decade and a half before.

In addition to practicing medicine in Lexington for the rest of his life, Dr. White was on the Staff of Virginia Military Institute. He died in 1902, survived by two sons and two daughters, William, Arch, Eleanor Hyde and Frances. The latter became Mrs. Paul Stahl Mertins, and would make the Alabama Capital City home for the rest of her life.

Her future husband was born in Evergreen, Alabama in 1879, the son of Jennie (von Stahl) and Gustav Ferdinand Mertins. This future Eye, Ear, Nose and Throat specialist received his early education at schools in Switzerland and Germany, later attending a boys' preparatory school in Massachusetts before entering Washington and Lee University at the age of 16. Four years later, with his A. B. degree from W. & L., he entered the Harvard School of Medicine for his M. D., going from there to internship in Boston and further studies in Vienna.

A veteran of 14 years' practice in Montgomery when World War I began, Dr. Mertins served through that conflict as a Navy lieutenant. He was a member of the American Academy of Otolaryngology and Ophthalmology and of the American College of Surgeons, a Montgomery Rotarian and a 13 Club member. When he died April 10, 1940, survivors included his widow and two children: Jane (Mrs. Felix Shanks) and Paul, Jr., already followed in his father's footsteps, a practicing otolarynogologist in Montgomery.

Paul Stahl Mertins, Jr., was educated at Barnes School, Montgomery; at Washington and Lee, from which he earned his baccalaureate; and at Columbia University College of Physicians and Surgeons, where he earned his M. D. He interned at Westchester County, New York, and served his residency at the Massachusetts Eye and Ear Infirmary before entering the service of his country. A Major in the Medical Corps, he served

(Continued on Page 1064)



Well, Dr. Cunningham! I was just telling Herbert I should talk to you about my allergy. First my nose starts to tickle and..."

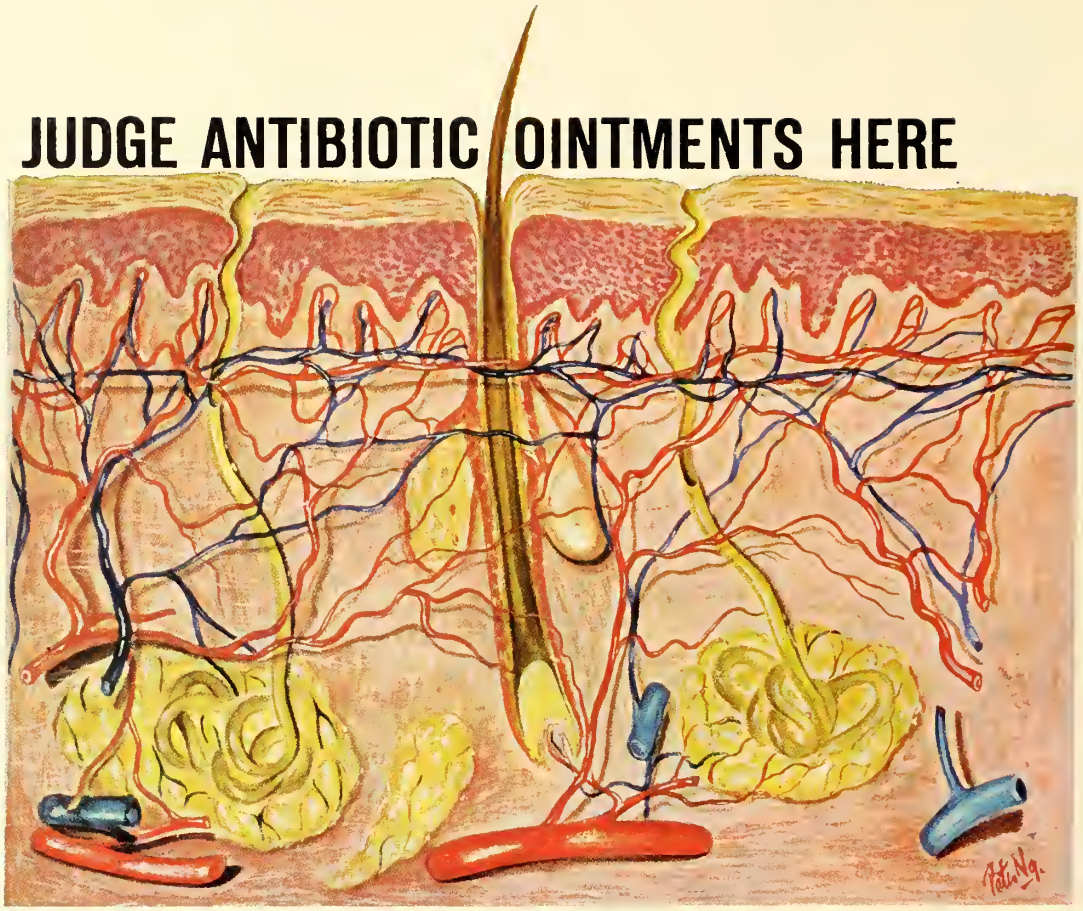
You know the rest of the story. Sneezing. Watery eyes. Rosy nose. And for prompt relief of these symptoms, here's Novahistine® LP. These continuous-release tablets have a vasoconstrictor-antihistamine formulation that begins working in minutes, then continues to provide relief for hours. Even when nasal congestion is due to repeated allergic episodes, two Novahistine LP tablets, morning and evening, let most patients breathe freely all day and all night. Use with caution in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Novahistine® LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

DOW THE DOW CHEMICAL COMPANY Rx Pharmaceuticals Indianapolis

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

IN ASTHMA
IN EMPHYSEMA



optional therapy

*

THE mudranes®

All Mudranes are bronchodilator-mucolytic in action, and are indicated for symptomatic relief of bronchial asthma, emphysema, bronchiectasis and chronic bronchitis. **MUDRANE tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **Iodide side-effects:** May cause nausea. Very long use may cause goiter. Discontinue if symptoms of iodism develop. **Iodide contraindications:** Tuberculosis; pregnancy (to protect the fetus against possible depression of thyroid activity). **MUDRANE-2 tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline. **Iodide side-effects and contraindications are listed above. MUDRANE GG tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **MUDRANE GG-2 tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions:** Those for aminophylline. **MUDRANE GG Elixir.** Each teaspoonful (5 cc) contains 26 mg. glyceryl guaiacolate; 20 mg. theophylline; 5.4 mg. phenobarbital (Warning: may be habit-forming); 4 mg. ephedrine HCl. **Dosage:** Children, 1 cc for each 10 lbs. of body weight; one teaspoonful (5 cc) for a 50 lb. child. Dose may be repeated 3 or 4 times a day. Adult, one tablespoonful, 4 times daily. All doses should be followed with ½ to full glass of water. **Precautions:** See those listed above for Mudrane GG tablets.

MUDRANE—original formula
First choice

MUDRANE-2
When ephedrine is too exciting or is contraindicated

MUDRANE GG
During pregnancy or when K.I. is contraindicated or not tolerated

MUDRANE GG-2
A counterpart for Mudrane-2

MUDRANE GG ELIXIR
For pediatric use or where liquids are preferred

Clinical specimens available to physicians.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals



CAUTION:

OVEREATING MAY BE HAZARDOUS TO YOUR HEALTH.

According to the Framingham Heart Study, the obese face:

86% greater risk of angina pectoris,
82% greater risk of diabetes,
71% greater risk of coronary heart disease.*

Obesity may also aggravate osteoarthritis, flat feet, intertriginous dermatitis, varicose veins, and ventral or diaphragmatic hernias.[1-3]

ou are considering weight reduction, consider

Preludin®
phenmetrazine hydrochloride
Endurets®
prolonged-action tablets

Often effective

Controlled studies in a general patient population have shown that when Preludin is used with diet, the rate of weight loss exceeds that obtained by placebo and diet.

Long acting

Slow, even release of the active principle usually suppresses appetite continuously for about 12 hours.

Once-a-day dosage

One Endurets tablet after breakfast. It helps reduce weight and costs, conveniently.

For contraindications, warning, precautions, and adverse reactions, please see the full prescribing information.
It is summarized on this page.

Where there's no will there's a therapeutic way.

*Among persons 20% or more overweight as compared with median weight for persons of like height and sex.

1. Kannel, W.B., *et al.*: *Circulation* 35:734, 1967.
2. Thomas, H.E., Jr., *et al.*: *Med. Times* 95:1099, 1967.
3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

Preludin®
phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.

Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.
Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000.
(B)R3-46-560-B

For complete details, please see full prescribing information.

Under license from
Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

PR-7169

(Continued from Page 1058)

from 1942 to 1946, principally with the 9th General Hospital in the Pacific Theater.

The younger Dr. Mertins is a member of the American Academy of Otolaryngology and Ophthalmology, and of the American College of Surgeons. He was the second Alabamian to be elected to membership in the Triological Society. And he has served as president of the Montgomery County Medical Society and of the Alabama Academy of Otolaryngology and Ophthalmology. He has been Chief of Staff of St. Margaret's Hospital and of Professional Center Hospital. Dr. Mertions is a member of Kappa Sigma Fraternity, of Phi Chi Medical Fraternity, of the Montgomery Rotary Club, and of Trinity Presbyterian Church.

In 1944 he was married to Miss Anne Moss of Birmingham and they have five children: Anne Cameron (Mrs. William McDow), married to a Navy lieutenant and presently stationed at Newport, Rhode Island; Ellen, a graduate student at Tulane University; Margery, a senior at the University of Denver; Scott, a freshman in the School of Architecture, Auburn; and Lee, a sophomore at Montgomery Academy. There is also one granddaughter, Molly McDow.

Spanning 80 Vital Years In Alabama History

Tumbling walls of a small brick building are all that remain in 1970 to mark the site of the once prosperous little Covington County town of Falco. In the early days of the 20th Century this building housed a drug store and the offices of the only physician there to look after the health and welfare of Falco's 2,500 inhabitants.

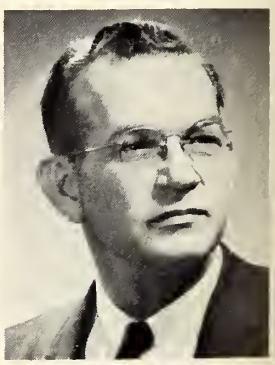
Hinton Wright Waters was born July 20, 1890, to Lilla P. (Flowers) and William Jefferson Waters in rural Pike County, on land granted to his great-grandfather, John Flowers by President John Quincy Adams in 1825 when Alabama was a fledgling state just 5½ years old.

When Hinton was ten, his father moved to town, to Brundidge, where there were urban conveniences. But he continued to farm his thousand-acre plantation. At this turn of the century, he built a colonial home that still stands, 70 years later.

Graduating from high school in Brundidge, the future Dr. Waters enrolled in the University of Alabama at Tuscaloosa, and it was here that he decided to study medicine. The next year he enrolled in the University of Alabama Medical School in Mobile from where he received his M.D. degree in 1913.



DR. WATERS, SR.



DR. WATERS, JR.

Newborn lumber camps dotted the lower 25 miles of Covington County, spoking out from a hub that was Falco, locale of the main mill of the McGowin and Foshee Lumber Company. It was a vast area covered with virgin pine, through which this young horse-and-buggy doctor would travel wagon ruts to his patients, the rough and tumble society of a frontier lumbering area that would make a TV western seem tame by comparison.

Two years after he set up practice in Falco, where a combined common sense and medical knowledge was already establishing him as an outstanding doctor in Covington County, Hinton Wright Waters, M.D., was mar-

(Continued on Page 1066)



The Bradley Center --- for the problems of living

An all new homelike open psychiatric residence on a lovely five-acre tract, centrally located within the community, providing a comprehensive range of continuous services, including in-patient, day care, and outpatient treatment. Each patient participates in an extensive and intensive treatment program, based almost exclusively upon multiple psychotherapeutic encounters. These include individual psychotherapy, group psychotherapy, the nursing milieu, occupational therapy, recreational therapy, topical small group discussions, and other group activities in the Center, as well as in the community, depending on individual needs and interests. Medications are prescribed when appropriate.

Any individual may be admitted who, in the opinion of the medical staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible family member.

Accredited by the Joint Commission on Accreditation of Hospitals.

Leonard T. Maholick, M. D.
Medical Director

Maj. Gen. (ret.) Howard Snyder
Administrator

THE BRADLEY CENTER, INC.
2000 Sixteenth Avenue
Columbus, Georgia 31901
Area Code 404 324-4882

(Continued from Page 1064)

ried to Mary Lucille Hamby, daughter of Lenora L. (Andrews) and Joseph Leon Hamby. And if any element was needed to assure the success of this promising young Falco physician, this element was the girl he married.

The first of five children born to them was Hinton Wright Waters, Jr., destined to become in after years a Montgomery physician with gynecology as his specialty. The other four, in order of their arrival, are William, now a Pensacola broker; Robert, now in real estate and insurance in Crestview, Fla.; Frances, now residing in Dothan with her lawyer husband; and Fred, a civilian purchasing agent at Eglin AFB, Fla.

But, as the Earl of Beaconsfield said in a political speech a century ago, "Change is inevitable. In a progressive country change is constant." The axes and saws of a busy lumber company razed the forests of south Covington County and the main mill was moved. Falco began to be swallowed up in the underbrush the mill had left behind. Dr. Waters moved his family to Opp, which to this day boasts that it is "the City of Opportunity."

This was in 1925, when his eldest son was nine years old.

The entire world went threadbare in the Great Depression that followed the market collapse of 1929, but Opp had suffered three telling blows to its economy in successive years preceding the panic. In 1926, 1927 and 1928, the Conecuh River burst its banks and flooded the town and the surrounding farms.

Still short of 40 years old, Dr. Waters, who was sandwiching house calls between the office treatment of 50 to 60 patients a day, delivering 20 to 25 babies a month, had to stop to hurry his beloved wife to a hospital 15 miles away. In those days before blood transfusions, she had suffered an internal hemorrhage. For many weeks she remained a hospital patient, first in Andalusia, then in Pensacola, and a semi-invalid for years afterward.

These were the days of the Great Depression when doctors' fees were paid with wood, syrup, turnip greens, vegetables, pork, chickens and a wonderful and truthful "thank you." Often the fee was declined or reduced where the doctor found conditions worse than in his own home. With an abiding faith in his country and in humanity, Dr. Waters continued to treat the maimed, the sick, and the economically broken. And as certainly as the darkest hour of night is just before dawn, the depression passed.

The children were educated as far as they wished, the mortagages were paid, the farms were saved, and during World War II the children found themselves with children of their own, either in school or in service, away from home. The war ended, the children's schooling was over, and Opp expanded from two doctors to five.

Dr. Waters' wife Mary meantime had opened an office pharmacy and often went to help with deliveries and "hold the smoke" (chloroform). Frequently there would be two or three in labor, miles apart, and she was often dispatched to the one least likely to deliver. Consequently many a time, the doctor would be delayed and the doctor's wife would be the mid-wife.

The 1950s were a happy time in the life of the Waters family. There was plenty of practice without obstetrics; children were coming home, grand-children arriving, redecorating the office and home, the farms changing from cotton and pecans to beef cows and pecans, with the herd and grasses alike improved. There was time for a cup of coffee between house visits. Sundays and Thursdays were special happy days for the entire family, when visits to the farms were scheduled.

A decade ago the legs of Dr. Waters began to fail him. It became necessary to ride the pastures. Arteriosclerosis hit both legs. The right foot developed gangrenous ulcers, but enlightened medicine saved it. He was not so fortunate with his left leg, and his old

classmate, Dr. W. C. Hannon of Mobile, found it necessary to amputate at mid-thigh. At 70 years of age, it was no easy task learning to walk with an artificial leg, and the other arteriosclerotic. Resuming practice was too much of an ordeal. Dr. Waters retired.

Meantime his son, Hinton Wright Waters, Jr., born in Falco, July 11, 1916, who had ridden with his father on many house calls and at night had opened the office to render first aid until his father could be found, decided that he too must follow the same destiny. With an A.B. degree from the University of Alabama, followed by a four-year course at Tulane, he received his M.D. degree.

His life dream was to enter practice with his father in Opp, but during internship at Baptist Hospital, New Orleans, he was dissuaded by a staff doctor, who helped him take up a residency in Obstetrics and Gynecology under Dr. Ed Plass at the University of Iowa. From there he returned to Opp. With house deliveries no longer feasible and with the nearest hospital 15 miles away, however, the junior Dr. Waters elected to move. He opened offices in Montgomery in January, 1946. Eight years later, in 1954, he discontinued obstetrics to restrict his practice to gynecology.

In 1947, he was married to Margaret Kemper of Demopolis, and they have three children: Hinton III, a junior at the University of Alabama; Kemper, a high school junior; and William, now in grade school. In addition to membership in county and state associations, this Dr. Waters is a past president of the Alabama Association of Obstetrics and Gynecology, a founding fellow of the American College of Obstetrics and Gynecology, head of the Department of Obstetrics and Gynecology and a director of Jackson Hospital, Montgomery.

And to return to the senior Dr. Waters, forced by his inability to walk comfortably, he returned to his first love, the farm. He spent much of his time in the early 1960s at Falco Farms, enjoying every minute with his cows and pecans. But no matter how great the good life is, the body can't stay young forever, not even for Mary and the senior Dr. Waters. Not one of the children was a farmer, nor did any settle near enough to help. The farms had to be sold, the last one in January of last year.

Today, full retirement is his reward for a busy lifetime. He plays dominoes daily at the retired men's dominoes club, visits children and friends, reads a monumental amount on a variety of subjects, and generally enjoys himself. Both Dr. and Mrs. Waters are in comparatively good health. And he promises his doctor friends and farmer friends alike that he will not bore them with advice on either score, should they care to visit him!

He will be 80 years old, come month after next.

Not just a motel
it's a Guest House

. . . with 171 handsome rooms designed for your comfort and convenience. A center-of-everything location including Birmingham's University of Alabama Medical Center . . . making The Guest House a favorite of Doctor's wives and in-town outpatients. Superb dining, dancing and nightly entertainment. Come stay with us often.

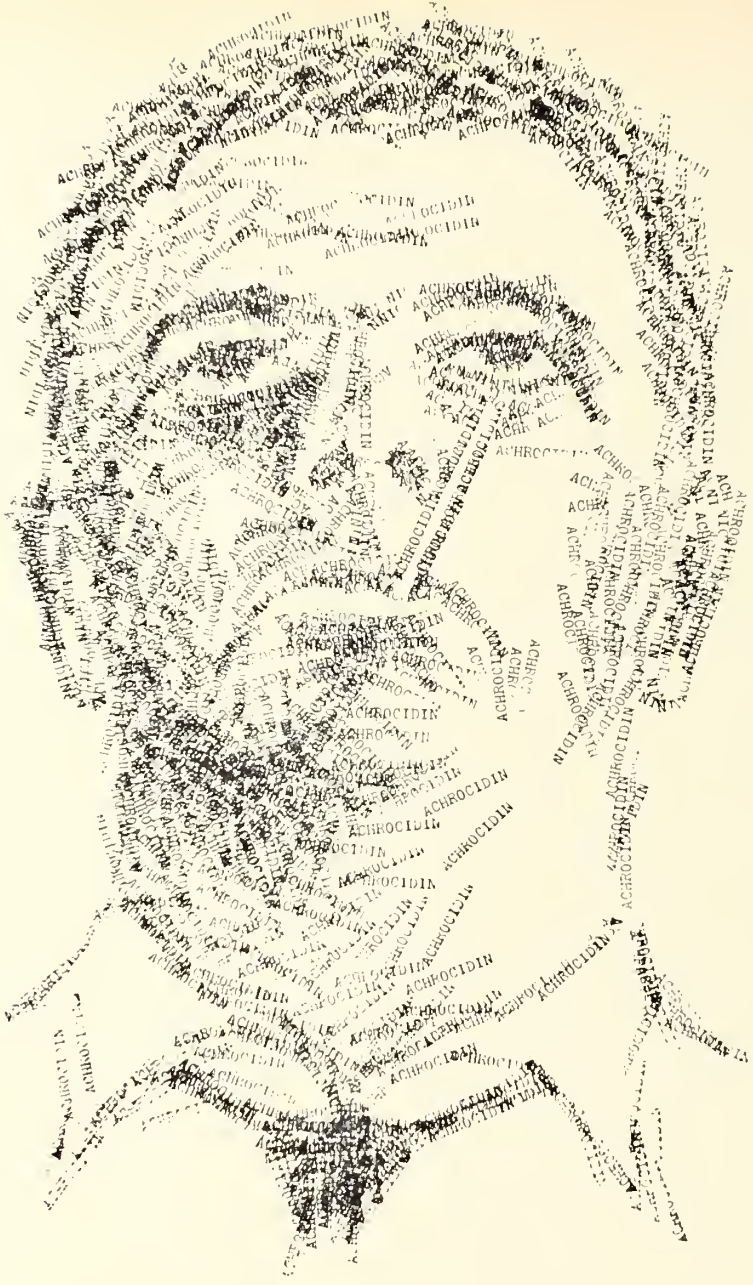
THE RESTAURANT
THE PLAYROOM • CYPRESS ROOM
CONVENTION FACILITIES



The Guest House
MOTOR INN

PHONE 324-8653
18TH ST. &
10TH AVE., SOUTH
BIRMINGHAM, ALABAMA

"Where the Action Is!"



Achrocidin® Tablets and Syrup

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen Citrate 25 mg.

ACHROCIDIN Tetracycline HCl—Antihistamine—Analgesic Compound Tablets and Syrup are recommended for the treatme of tetracycline-sensitive bacterial infection which may complicate vasomotor rhinitis, sinusitis and other allergic diseases of t upper respiratory tract, and for the concomitant symptomatic relief of headache and nasal congestion. For children and elde patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN Tetracycline equivalent Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 n

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliat dermatitis; photosensitivity; onycholysis, discoloration. *Kidney*—dose-related rise BUN. *Hypersensitivity reactions*—urtica angioneurotic edema, anaphylaxis. *Intracra* —bulging fontanels in young infants. *Tee* yellow-brown staining; enamel hypopla *Blood*—anemia, thrombocytopenic purp neutropenia, eosinophilia. *Liver*—cholestasi high dosage.

Upon adverse reaction, stop medication treat appropriately.

Millions May Go To Stimulate Family Medicine



A BILL AUTHORIZING $425 MILLION to support training programs for family doctors and others in the field of family medicine is given a last-minute check by Sen. Ralph Yarborough (D.-Tex.), seated, before introducing the bill in the Senate.

Dr. Edward J. Kowalewski, Akron, Pa., standing left, president of the American Academy of General Practice, and Dr. Robert O. Quello, Minneapolis, chairman of the Academy's Board of Directors, express approval of the bill which was introduced on the first anniversary of the announcement of the approval of family medicine as a primary medical specialty. The bill was introduced simultaneously in the House of Representatives by Rep. Fred Rooney (D.-Pa.).

The bill, whose funds would be appropriated through 1975, provides for grants to be made by the Secretary of Health, Education and Welfare to (1) medical schools; (2) teaching hospitals, and (3) interns and residents who plan to make family medicine their specialty.

The proposed legislation was introduced on the first anniversary of the announcement of the approval of family medicine as a primary medical specialty. The specialty became a fact when the Council on Medical Education of the American Medical Association and the Advisory Board for Medical Specialties approved a certifying board in family medicine in 1969 just prior to the annual Congress on Medical Education in Chicago.

Since that time the AMA and the American Academy of General Practice, the national association of family physicians and a sponsor of the new certifying board, have placed major emphasis on educational programs at the residency level to begin preparing young doctors for specialty certification in this field.

The Yarborough-Rooney legislation is designed to assist medical schools and teaching hospitals to set up quality family practice departments and programs to produce highly-qualified family doctors as quickly as possible. The shortage of primary physicians has been widely recognized as a basic shortcoming in the American medical system.

The bill defines family medicine as "those certain principles and techniques and that certain body of medical, scientific, administrative and other knowledge and training which specifically equip and prepare a physician to engage in the practice of family medicine." Family practice then is defined as the "practice of medicine by a physician . . . who specializes in providing to families . . . comprehensive, continuing professional care and treatment of the type necessary or appropriate for the general health maintenance."

Among major provisions of the bill is that an Advisory Council on Family Medicine be set up to assist the Secretary of HEW to

award grants. This council would review all grant applications and recommend approvals to the Secretary. The council would be composed of (1) four doctors engaged in the practice of family medicine; (2) four doctors engaged in the teaching of family medicine, and (3) four persons representing the general public. The council initially would help the Secretary set up regulations for execution of the legislation.

The bill covers not only financing the operation of training programs in family medicine but also construction of facilities designed to make such programs functional. Also covered are training programs designed to produce heads of departments and teachers of family medicine. In addition, the bill incorporates a provision for training paramedical personnel—non-M. D. medical personnel —to work in the field of family medicine.

The appropriations schedule calls for 50 million dollars through the end of fiscal 1971, 75 million from then until June 30, 1972, and then 100 million dollars each year for the remaining three years through June 30, 1975.

Missouri Has Most Dermatologists

The School of Medicine of the University of Missouri-Columbia tops the field in living graduate dermatologists in the nation, based on per 1,000 graduates, say to statistics released recently by the American Medical Association, according to *Missouri Medicine.*

Missouri graduated its first class of MDs in 1957. With the completion of the Medical Center in Columbia, the medical curriculum was extended to the four years necessary to graduate MDs. And according to the AMA report, based on graduates through Dec. 31, 1957, the graduates of the University of Missouri School of Medicine who have gone on for further training in dermatology numbers 28.4 per cent.

As "number one" in the production of dermatologists, Missouri is followed by UCLA, Duke, Michigan, Puerto Rico, West Virginia, Rush (University of Chicago), USC, Buffalo and New Jersey, in that order, the magazine reported.

Obstetric and Gynecologic Seminar Scheduled

The 16th Annual Southern Obstetric and Gynecologic Seminar will be held this year at Grove Park Inn in Asheville, N. C., from Monday, July 27, through Friday, July 31. A wide variety of obstetric and gynecologic subjects will be covered including cryosurgery, vaginal surgery, cervical dysplasia and carcinoma, obstetrical anesthesia, infertility and hormonal and pituitary ovarian balance studies.

The active faculty this year will be Dr. Bayard Carter of Duke University, Dr. Robert Barter of Washington, Dr. Raymond Kaufman and Dr. Robert Franklin of Baylor University, Dr. Robert Greenblatt of Georgia, Dr. Duane Townsend of California and Dr. Charles Hendricks of the University of North Carolina.

The S e m i n a r is designed for informal teaching with many open discussions and panels. Registration is limited to the first fifty applicants.

For information and registration please write Dr. George T. Schneider, Ochsner Clinic, 1514 Jefferson Highway, New Orleans, Louisiana 70121.

Wars are always, and revolutions are nearly always, nasty, brutal, barbarous, stupid, sordid, and dreary. They are, while they last, the antithesis of civilization.

—Leonard Woolf

From Walking To Wings In Less Than a Century of Medicine

From the horse-and-buggy days of medicine to winged medicine is a span of less than a century in time, but in distance it is from here to infinity! For medicine may be found wherever people may be found—and people may be found anywhere in outer space.

For the present, however, medical practice has expanded in less than a hundred years from the limits of a few miles to the remotest corners of earth. Wings have made the expansion possible, and doctors who fly are pioneers in this expansion.

At the last count, the Flying Physicians Association numbers a modest 23 members in Alabama, though this is only a fraction of the physicians in this state who fly. Each month since last summer, *The Journal of the Medical Association of the State of Alabama* has carried a sketch of one of these 23.

The current subject is Charles Brandon Crow, Jr., M. D., Birmingham internist. And the trip that took three planes from Birmingham during the 1970 A.E.A. holidays south to a remote island in the Lesser Antilles is a vivid illustration of what medicine is doing with its recently acquired wings.

Alabama doctors, dentists and amateur radio operators made the trip, setting up and operating a combined medical and dental missionary clinic on Anguilla, just 60 miles north of St. Kitts, among a population estimated at just over 5,000.

The Flying Physicians Association, which still numbers less than 3,000 members in the world, has a three-fold objective: to promote aviation safety, to research into the medical aspects of aviation, and to stimulate aviation interest among physicians. Dr. Crow is on the Tour Committee of F.P.A., which is headed by Dr. Willis Taylor of Omaha, Nebraska, and whose primary responsibility is planning tours, usually a summer and winter tour each year. These have proved highly successful, involving anywhere from ten to 40 aircraft with from 30 to more than a hundred participants. Medical meetings are held at points along the tour, in which local physicians and F.P.A. members participate. Tours have ranged from Alaska to Mexico, from the Maritime Province to the Bahamas, and from Canada to Colombia, with Central America and the Carribbean Islands in between.



VICE PRESIDENT OF BIRMINGHAM'S SOARING SOCIETY, Dr. Charles B. Crow, Jr., is also an enthusiastic member of the Flying Physicians Association. He is shown here at the controls of the Society's Sweitzer 2-33 sailplane.

The grandson and great-grandson of two United States Senators, Dr. Crow stems from the foremost political family in Alabama in the 20th Century—the Bankheads. His mother was the daughter of the late Senator John Bankhead, which makes him the grandnephew of the late Speaker of the House Will Bankhead and of the late Marie (Bankhead) Owen, and a cousin of the celebrated actress Tallulah Bankhead. As a matter of fact his younger brother, with whom he is associated in medical practice is named for their grandfather, John Bankhead Crow, M. D.

Dr. Charles B. Crow, a graduate of the

University of Alabama and of Johns Hopkins, a past president of the Birmingham Society of Internists, a Fellow of the American College of Gastroenterology and past Alabama Governor, is also an author, co-bylining with Harold C. Steele, Ed. D., a recently published book, *High Blood Pressure, Cholesterol and You*, and the two are now working on another, probably to be titled *The Promise of Medicine*. The books are aimed primarily at a lay audience.

Incidentally, Dr. Crow has become interested in gliders, recently a founding member of the Birmingham Soaring Society, serving as vice president. With a glider and a tow plane the group of some 35 enthusiastic members operates from a sod field in a lovely setting by a lake in Alabaster, where they take their families for weekend picnics, to play ball and watch the soaring activities.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

Laboratory Combined Division All Reports for Period February, 1970

	No. Specimens Received
General Bacteriology	2,280
Virology	239
Parasitology	1,751
Enteric Bacteriology	242
Fluorescent Microscopy	5,801
Tuberculosis	5,067
Mycology	66
Milk and Dairy Products	5,374
Water	3,269
Sea Foods	141
Syphilis Serology	30,738
Special Serology	1,645
Metabolic Diseases	7,476
Cytology	3,314
Chemistries	223
Miscellaneous	2,758
Total Number of Specimens Received	70,384

BUREAU OF PREVENTABLE DISEASES

Frederick S. Wolf, M. D., Director

Current Morbidity Statistics

1970

	Dec.	Jan.	*E. E. Jan.
Tuberculosis	76	108	107
Syphilis	33	31	115
Gonorrhea	525	656	349
Chancroid	2	0	2
Typhoid fever	0	0	0
Salmonella	12	18	3
Undulant fever	0	0	0
Shigella	2	10	5
Amebic dysentery	2	1	2
Scarlet fever & strep. throat	777	962	310
Diphtheria	0	0	0
Whooping cough	5	1	6
Meningitis	5	8	4
Tularemia	0	0	0
Tetanus	2	0	0
Poliomyelitis	0	0	0
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	2	4	96
German measles	7	16	6
Chickenpox	73	138	104
Mumps	23	31	81
Infectious hepatitis	35	35	35
Typhus fever	0	0	0
Rocky Mt. spotted fever	0	0	0
Malaria	0	2	0
Cancer	471	919	479
Rheumatic fever	2	18	19
Rheumatic heart	18	29	26
Influenza	89	3,035	198
Pneumonia	273	511	332
Rabies—Human cases	0	0	0
Pos. animal heads	3	3	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF PREVENTABLE DISEASES

Frederick S. Wolf, M. D., Director

Current Morbidity Statistics

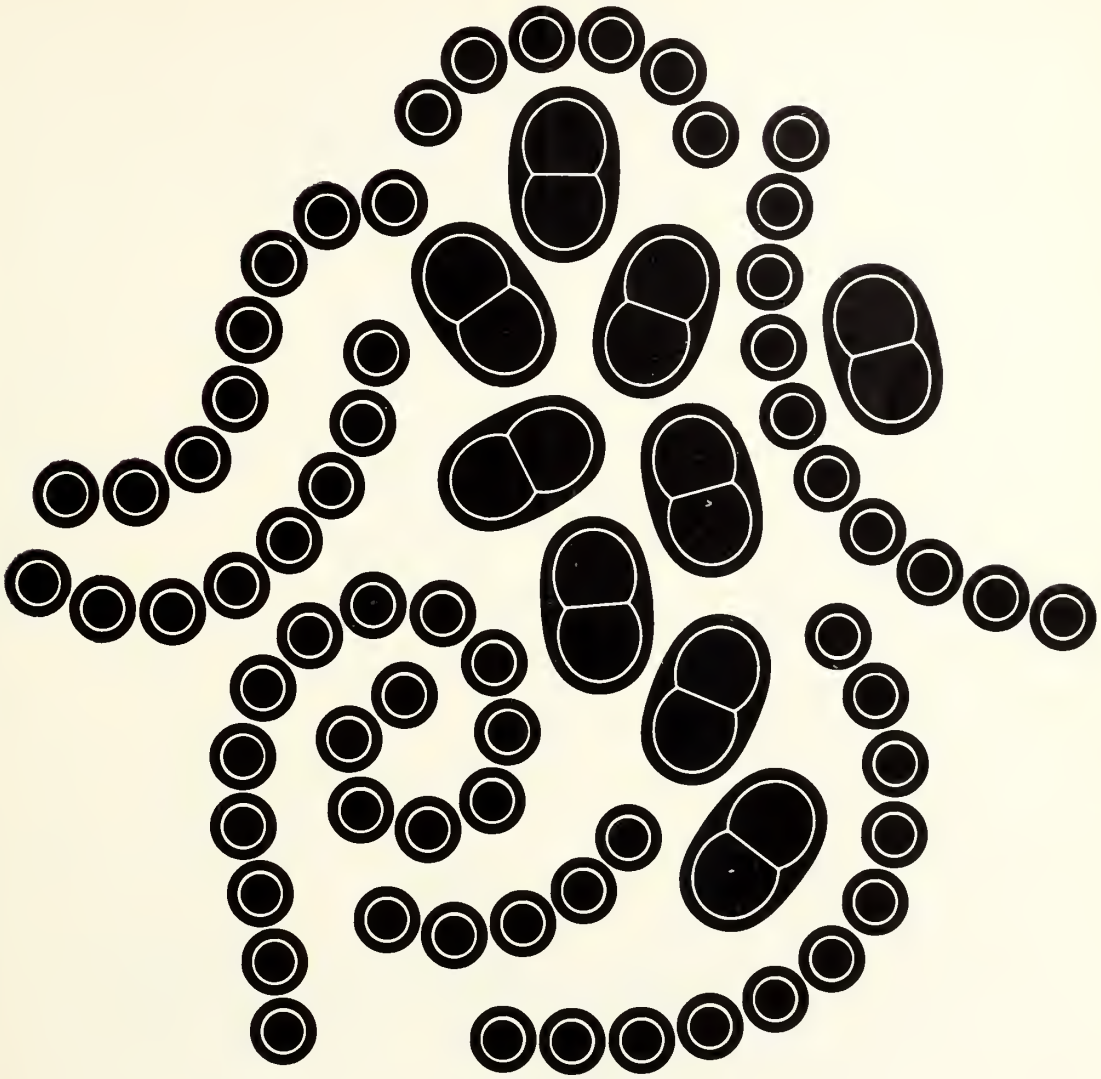
1970

	February	March	*E. E. March
Tuberculosis	86	70	118
Syphilis	38	23	126
Gonorrhea	369	624	335
Chancroid	0	2	1
Typhoid fever	0	1	0
Salmonella	10	16	2
Undulant fever	0	0	0
Shigella	2	8	3
Amebic dysentery	0	0	4
Scarlet fever & strep. throat	713	503	326
Diphtheria	0	0	1
Whooping cough	2	1	7
Meningitis	5	3	7
Tularemia	0	0	0
Tetanus	0	0	0
Poliomyelitis	0	0	0
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	9	11	314
German measles	29	79	14
Chickenpox	119	164	112
Mumps	39	32	55
Infectious hepatitis	27	19	41
Typhus fever	0	0	0
Rocky Mt. spotted fever	0	0	0
Malaria	3	3	0
Cancer	379	418	669
Rheumatic fever	9	15	17
Rheumatic heart	19	14	24
Influenza	30,997	2,926	1,638
Pneumonia	760	610	348
Rabies—Human cases	0	0	0
Pos. animal heads	9	0	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

during and after infection



Berocca®

TABLETS
high potency B-complex and C
for nutritional support

AVAILABLE ONLY ON Rx

contains water-soluble vitamins only

b.i.d. dosage

good patient acceptance

no odor, and virtually no aftertaste

Each Berocca Tablet contains:

Thiamine mononitrate	15 mg
Riboflavin	15 mg
Pyridoxine HCl	5 mg
Niacinamide	100 mg
Calcium pantothenate	20 mg
Cyanocobalamin	5 mcg
Folic acid	0.5 mg
Ascorbic acid	500 mg

Usual dosage is one tablet b.i.d.

Indications: Nutritional supplementation in conditions in which water-soluble vitamins are required prophylactically or therapeutically.

Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B_{12}.

Dosage: 1 or 2 tablets daily, as indicated by clinical need.

Available: In bottles of 100.

ROCHE

Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

INDEX TO ADVERTISERS

Arch Laboratories ... 992

Blue Cross-Blue Shield ... 1038
The Bradley Center ... 1065
Breon Laboratories ... 1001
Burroughs Wellcome ... 1060

Campbell Soup ... 1025
Comal Pharmaceuticals ... 1007

Dow Chemical ... 1059

Flint Laboratories ... 1032, 1033

Geigy Pharmaceuticals ... 1062, 1063
Guest House Motel ... 1067

Highland Hospital ... 985
Hoechst Pharmaceuticals ... 1049
Hynson, Westcott & Dunning ... 979

Lederle Laboratories ... 981, 1003, 1068, 1074
Eli Lilly & Company ... 1st Cover, 1010

Merck, Sharp & Dohme ... 1044, 1045, 1046
Wm. S. Merrell ... 3rd Cover

National Drug ... 2nd Cover, 997, 998

Pfizer Laboratories ... 988, 989, 990
Wm. P. Poythress ... 1028, 1061

Roche Laboratories ... 983, 1073, 4th Cover

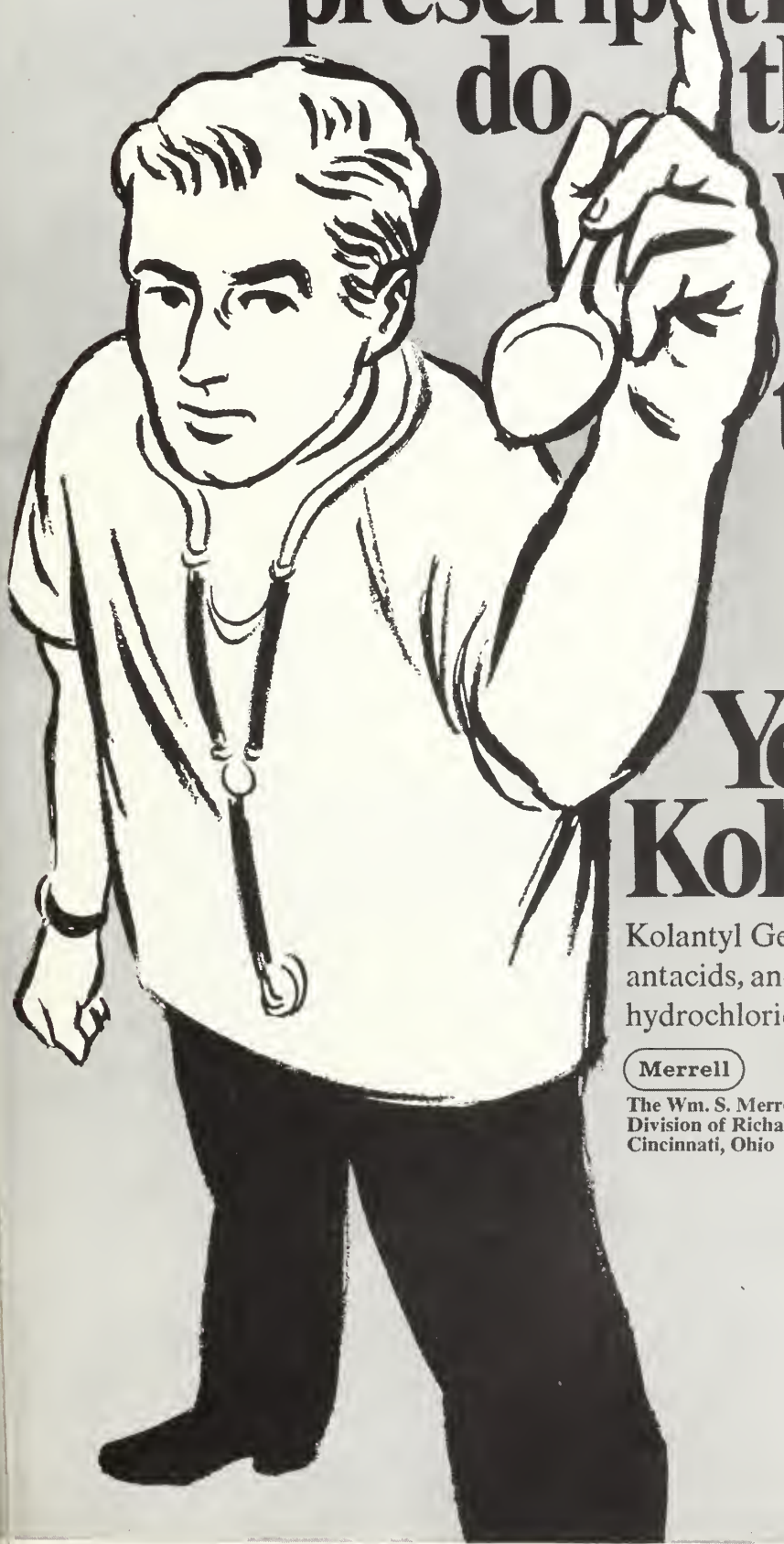
Julius Schmid ... 1036, 1037
G. D. Searle ... 1026, 1027
Stuart Company ... 1008

Wyeth Laboratories ... 1053, 1054

—The lowest priced tetracycline—nystatin combination available—



Can one prescription do the work of two?

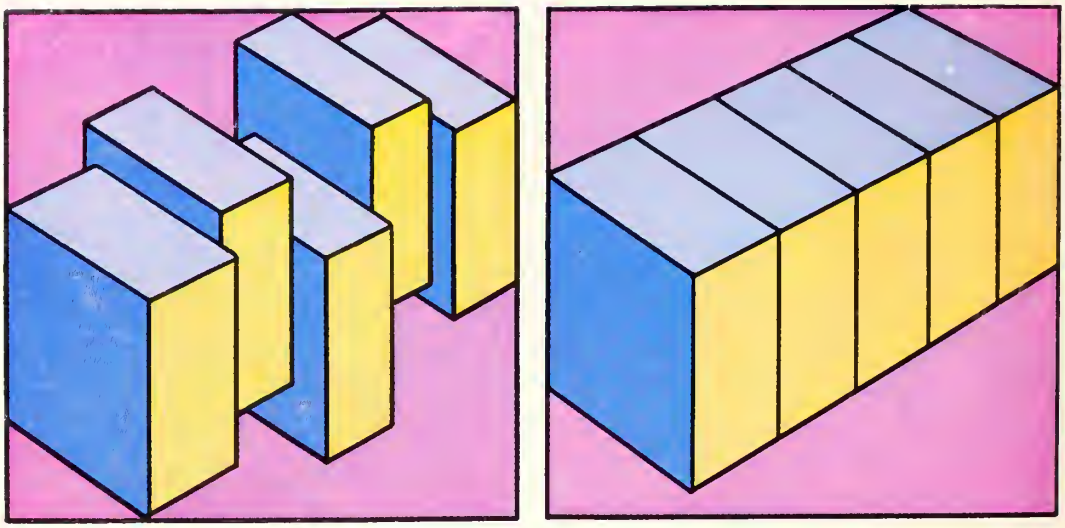


Yes, Kolantyl®.

Kolantyl Gel/Wafers contain antacids, and Bentyl® (dicyclomine hydrochloride) too.

Merrell

The Wm. S. Merrell Company
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215



from the discord of anxiety...

to emotional harmony

Before prescribing, please consult complete product information, a summary of which follows:

INDICATIONS: Indicated when anxiety, tensian and apprehensian are significant campanents af the clinical prafile.
CONTRAINDICATIONS: Patients with knawn hypersensitivity ta the drug.
WARNINGS: Cautian patients abaut passible cambined effects with alcahal and ather CNS depressants. As with all CNS-acting drugs, cautian patients against hazardaus accupatians requiring complete mental alertness (e.g., aperating machinery, driving). Thaugh physical and psychalagical dependence have rarely been reparted an recammended dases, use cautian in administering ta addictian-prane individuals ar thase wha might increase dasage; withdrawal symptams (including canvulsians), fallawing discantinuatian af the drug and similar ta thase seen with barbiturates, have been reparted. Use af any drug in pregnancy, lactatian, ar in wamen af childbearing age requires that its potential benefits be weighed against its passible hazards.
PRECAUTIONS: In the elderly and debilitated, and in children over six, limit ta smallest effective dasage (initially 10 mg ar less per day) to preclude ataxia ar aversedatian, increasing gradually as needed and talerated. Not recammended in children under six. Thaugh generally not recommended, if cambinatian therapy with ather psychatrapics seems indicated, carefully cansider individual pharmacalagic effects, particularly in use of patentiating drugs such as MAO inhibitars and phenathiazines. Observe usual precautians in presence af impaired renal ar hepatic functian. Paradaxical reactions (e.g., excitement, stimulatian and acute rage) have been reparted in psychiatric patients and hyperactive aggressive children. Emplay usual precautions in treatment af anxiety states with evidence af impending depression; suicidal tendencies may be present and pratective measures necessary. Variable effects on blood coagulation have been reparted very rarely in patients receiving the drug and aral anticaagulants; causal relationship has nat been established clinically.
ADVERSE REACTIONS: Drawsiness, ataxia and canfusian may accur, especially in the elderly and debilitated. These are reversible in mast instances by praper dosage adjustment, but are alsa accasianally observed at the lawer dasage ranges. In a few instances syncape has been reparted. Alsa encauntered are isalated instances af skin eruptions, edema, minar menstrual irregularities, nausea and canstipatian, extrapyramidal symptams, increased and decreased libida--all infrequent and generally cantrolled with dasage reductian; changes in EEG patterns (law-valtage fast activity) may appear during and after treatment; blaad dyscrasias (including agranulacytasis), jaundice and hepatic dysfunctian have been reparted accasianally, making periadic blaad caunts and liver function tests advisable during pratracted therapy.

with the aid of antianxiety

Librium®
(chlordiazepoxide HCl)

5-mg, 10-mg and 25-mg capsules

In an age of swift change and challenge, susceptible individuals may experience varying degrees of excessive anxiety. The resulting emotional stress may precipitate significant functional disorders ar complicate existing organic disease. In properly individualized maintenance dosage, Librium (chlardiazepoxide HCl) quickly helps relieve anxiety and apprehensian, pravides useful adjunctive therapy in psychophysialogic disorders. In long clinical experience, Librium has demonstrated a wide margin of safety.

Also available:
Libritabs®
(chlordiazepoxide)

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

JOURNAL of the Medical Association of the State of ALABAMA

DISPLAY SHELVES
STATE OF ALABAMA • 1873 • THE MEDIC

IN THIS ISSUE

A Proposal for the Management of Hodgkin's Disease 1107

Pulmonary Function Testing for the General Hospital and Physician (Part VI) 1113

Peer Review and Medicaid 1125

THE FRANCIS A. COUNTWAY LIBRARY OF MEDICINE BOSTON

29 JUN 1970

Francis A. Countway Lib. of Medicine
10 Shattuck St.
Boston, Massachusetts 02115



TES-TAPE®
Urine Sugar Analysis Paper

Snip, dip, compare—that's all

An easy, accurate test-paper method for the qualitative and semiquantitative determination of urine glucose

Additional information available upon request.

Lilly
Leadership in Diabetes Research for Half a Century

Eli Lilly and Company • Indianapolis, Indiana 46206

000118

JUNE 1970

The girth control pill



Tepanil® Ten-tab®
(continuous release form)

(diethylpropion hydrochloride)

works on the appetite not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. *Sympathomimetic cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. *Allergic phenomena* reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-006A / 8/70 / U.S. PATENT NO. 3,001,910

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON

29 JUN 1970

LACTINEX®

TABLETS & GRANULES

■ **to help restore and stabilize the intestinal flora**

■ **for fever blisters and canker sores of herpetic origin**

Lactinex contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.[1,2,3,4,5,6,7,8]

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.

Baltimore, Maryland 21201

(LX-05)

References:
er, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., 7, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. ekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, ENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: rg., Oral Med. & Oral Path., *20*:591-593, November 1965.

THE JOURNAL

of the

Medical Association of the State of Alabama

Volume 39 • June, 1970 • No. 12

Office of Publication
19 So. Jackson St. — Montgomery, Ala. 36104
Subscription Price — $5.00 Per Year
$1.00 Per Copy

Second Class Postage Paid at Montgomery, Alabama. Published monthly in Montgomery at 19 South Jackson Street.

Editor-in-Chief
William L. Smith, M. D. — Montgomery

Managing Editor
L. P. Patterson — Montgomery

Assistant Managing Editor
Mary Nell Williford — Montgomery

Associate Editors
J. P. Collier, M. D. — Tuscaloosa
John M. Chenault, M. D. — Decatur
M. Vaun Adams, M. D. — Mobile

Officers of the Association

President
S. Buford Word, M. D. — Birmingham

President-Elect
A. E. Thomas, M. D. — Montgomery

Vice-Presidents
F. M. Phillippi, Jr., M. D. — Brewton
J. E. Cameron, M. D. — Alexander City
O. Emfinger, M. D. — Union Springs
Wood S. Herren, M. D. — Birmingham

Secretary-Treasurer
William L. Smith, M. D. — Montgomery

Executive Director
L. P. Patterson — Montgomery

The State Board of Censors
John M. Chenault, M. D., Chmn. — Decatur
J. P. Collier, M. D. — Tuscaloosa
Paul W. Burleson, M. D. — Birmingham
L. L. Hill, M. D. — Montgomery
M. Vaun Adams, M. D. — Mobile
J. D. Bush, M. D. — Gadsden
E. L. Strandell, M. D. — Brewton
John W. Davis, Jr., M. D. — Montgomery
J. Garber Galbraith, M. D. — Birmingham
H. G. Hodo, M. D. — Fayette

State Health Officer
Ira L. Myers, M. D. — Montgomery

Delegates and Alternates to the American Medical Association
(Terms expiring December 31 of year shown.)

1970
Delegate—E. Bryce Robinson, Jr., M. D., — Fairfield
Alternate—W. E. White — Anniston

1971
Delegate—M. Vaun Adams, M. D. — Mobile
Alternate—E. L. McCafferty, Jr., M. D. — Mobile
Delegate—P. W. Burleson, M. D. — Birmingham
Alternate—Robert Parker, M. D. — Montgomery

1972
Delegate—E. Bryce Robinson, Jr., M. D. — Fairfield
Alternate—W. E. White — Anniston

CONTENTS

President's Page — 1078

The Woman's Auxiliary — 1080

Editorial Comment — 1082

- We've Traveled Far—But Now, Quo Vadis? — 1082
- And Now MASA Looks Ahead To 110th Annual Session — 1083

Legal Page — 1090

- Legal Problems In Medical Practice Partnerships — 1090

Malpractice And Basic Legal Principles — 1095

Comments Of Birmingham Doctor In Medical Journal — 1103

Scientific Section — 1107

- A Proposal For The Management Of Hodgkin's Disease At The University Of Alabama Medical Center, Birmingham, Alabama; Donn J. Brascho, M. D.; John R. Durant, M. D.; Frank G. Moody, M. D.; Robert E. Roth, M. D., and William A. Maddox, M. D. — 1107
- Pulmonary Function Testing For The General Hospital And Physician, Part VI, D. S. Tysinger, Jr., M. D., Dothan, Alabama — 1113

Association Forum — 1125

- Peer Review And Medicaid, Paul I. Robinson, M. D. — 1125

Around The State — 1129

- New Physicians Licensed To Practice In Alabama — 1129

Hobbies To Fill A Doctor's Leisure — 1132

- Man's Best Friend As A Happytime Pursuit — 1132

Doctors Who Play With Fire (Their Favorite Recipes) — 1136

Fathers And Sons In Medicine — 1137

- Four Doctors And 120 Years In Medical-Practice History — 1137
- When Alabama Knew Three Doctors "Jimmy" Watkins — 1139

AMA Annual Convention In Chicago, June 21-25 — 1142

From Medicine's Yesterdays To Medicine's Tomorrows
Dr. Tinsley Harrison Takes A Look — 1146

The Month In Washington — 1155

HEW, AFL-CIO, Senior Citizens Join Crusade Against Chiropractic — 1160

Greensboro M. D., On The Wing Of His Cherokee — 1164

The Mentally Ill—From Plato To Bedlam To Now — 1165



A urinary tract infection was eliminated last week

ıtestinal monilial overgrowth has appeared this week

For women who are diabetic or debilitated, oral antibiotic therapy often sets the stage for monilial overgrowth in the intestine.

When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin—it helps avoid monilial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

It doesn't let monilia begin where bacteria end. Declostatin® 300

Demethylchlortetracycline HCl 300 mg and
Nystatin 500,000 units Capsule-Shaped Tablets Lederle

Effectiveness: Because its antibacterial component is DECLOMYCIN® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 450-9

President's Page



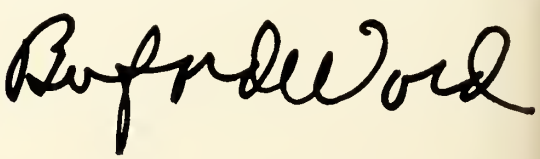
S. Buford Word, M. D.

COUPLING DELIVERY OF HEALTH CARE WITH THE DEMAND

Most members of our Association are so busy we have little time for matters beyond our finger-tips. In the mad rush our thoughts seem to come without thinking. It is a fact that the delivery of health care and the demand has recently become out of joint. The need to couple them again is urgent. The comments on this page will raise more questions than contain solutions. The problem, however, is of such enormity that it demands thoughtful consideration by members of the Association.

The recently implemented federal and state programs that has overloaded the present system of medical care for the citizens of this state is of recent origin and is expected to worsen. More medical schools in our state may help in the future but the immediacy of the situation prevents this from being the total solution. It will take a decade for a medical school now on the planning board to furnish graduates who could assume the responsibility of delivering health care to our citizens. Since health care, for a large segment of our citizens, has become a right, it has been estimated that fifty percent of each Doctor's patient load is composed of apprehensive individuals labeled, "The worried well". These patients cannot be catagorized without a thorough examination. It may be that the future physicians of the world will become health monitors whose time will be consumed diagnosing future illnesses his patients are likely to develop and giving advice to prevent such illness or minimize the attack when it does occur, twenty years hence. Hopefully the seriously ill would be less in number under such a system.

The immediate problem is not of the future but one of finding a way to increase the reach of the practicing physician in the overloaded areas now. It came to my attention at the recent meeting in Mobile, that some members of our Association are seeing as many as one hundred and forty patients a day which includes twenty to thirty hospitalized ones, some of whom are, no doubt, seriously ill. No one in solo practice can do his best day after day with this over demand. If this situation becomes more prevalent throughout the state, we can expect a return of the "herb doctor". Members of the profession of our state who have assumed the guardianship of the health of our citizens must develop a system of delivery of health care that is of the highest quality and in keeping with the traditions, the customs and the dignity of excellent medical care for all of our citizens. A search for the solution to this problem should be of thoughtful concern to every physician in Alabama.



S. Buford Word, M. D.



- Meet the Personal and Professional Challenge of the 1970's

These scientific sessions, special programs, exhibits and films will help you practice better medicine. Plan now to attend the AMA Convention.

- The Comatose Patient and the Diagnosis of Death
- Conception Control and Abortion
- Delivery of Health Care—The Role of the Allied Health Personnel
- The Role of the Physician in Family Life, Education, etc.
- Kidney Disease
- Hepatitis
- The Suicidal Patient
- Drug Interactions and Adverse Reactions
- Occupational Diseases of Current Interest
- Plastic and Maxillofacial Surgery
- Nuclear Medicine
- Daily Showing of newest Medical Films
- 250 Scientific Exhibits—the latest research
- Multidiscipline Research Forum

Complete details of the Scientific Program are in the May 4, 1970 issue of the *Journal of the American Medical Association.*

Check it carefully. Then use the housing and advance registration forms appearing in *JAMA* and the *American Medical News* to insure your place at the world's largest medical convention.

The Woman's Auxiliary

President, Mrs. Howard C. Johnson
President-Elect, Mrs. Gilder Wideman
Northeast District Vice President, Mrs. James D. Holliman, Jr.
Northwest District Vice President, Mrs. George Hansberry
Southeast District Vice President, Mrs. D. S. Tysinger
Southwest District Vice President, Mrs. Watson Maxwell
WAMASA Editor, Mrs. William L. Smith

AUXILIARY PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the Medical Association of the State of Alabama. I will support its activities, protect its reputation and ever sustain its high ideals."

The Convention in Mobile was delightful. Our thanks go to the Mobile County Medical Society and its Auxiliary for the many, many hours of hard work that went into making it a memorable one.

Father Daniel Eagan's talk, "Crime and Drug Addiction" given at Thursday's luncheon was outstanding. I'm sure you agree with me that the "Gaslight Party" was great from seafood to Morgan-Lawrence's Bunnies! I congratulate them for winning the first prize, and also congratulate the other three counties which presented skits: Montgomery-Autauga, Jefferson-Birmingham, and Mobile. There were three prizes of $100 each, and first place prize was $200 all to be given to AMA-ERF Auxiliary Fund by these Auxiliaries. The Auxiliary members appreciate being included each year in the ALAPAC Luncheon, and always enjoy it. Certainly this year was no exception. Governor Brewer should be commended for keeping his talk non-political when it was given only five days before election day. The Awards Dinner, too, was most enjoyable.



Mrs. Howard C. Johnson

The Auxiliary Sessions were meaningful and informative. Mrs. William J. Rosser, past State President, was presented a State Honorary Membership. Our own Belle Chenault, President, Woman's Auxiliary to the AMA was our honored guest throughout the convention. We were also pleased to have as our guest, Mrs. Gordon Peek, President, Woman's Auxiliary to the Southern Medical Association.

The Auxiliary membership is at an all time high, 1508. During 1969-70 we gained 208 new or reinstated members, and have two newly organized County Auxiliaries. Let me take this opportunity to tell the doctors of Lee and Autauga counties how delighted we are to have their wives as members.

The Auxiliary was quite proud when Mrs. Richard Dillard, AMA-ERF Chairman, presented a check for $16,000 to Dr. Clifton K. Meador, Dean of the Medical College of Alabama. Doctors, please remember when you make your contribution to AMA-ERF to

make out your check to AMA-ERF *Auxiliary Fund,* designate the Medical School of your choice, and send it either to your local AMA-ERF Chairman or to the State Chairman: Mrs. Ben H. Johnson, Jr., One Meadow Lane, Bessemer, 35020.

The theme of the Auxiliary for the coming year is, "Service to Others." All projects will be projected with this in mind. We agree with Dr. Albert Schweitzer's statement, "He who seeks to serve others has found the meaning of life." Unless we give of ourselves, we fall short of making our best contribution to our communities, our state, and our nation. We are ever ready to serve the Medical Association in whatever way you may wish.

Sincerely,



Camille Johnson

Experiments Risky In Cataract Surgery

A warning to the general public against new, risky and experimental cataract surgery has been issued by the American Academy of Ophthalmology and Otolaryngology through the Alabama division of that specialist group. The full text of the statement follows:

Cataract surgery has been developing for the past 100 years and is now one of the most successful of all operations.

The first operation was called couching. A needle was thrust into the eye and the cataractous lens pushed back into the eye out of the pupil. Improved vision was temporary.

The next operation was the extracapsular operation. The lens had to ripen or soften and was partly removed by leaving the capsule in the pupil. This capsule left in the pupil often caused blurred vision.

The next improvement was the total removal of the lens and capsule called intracapsular operation. This gives best vision and is the most common modern operation. Improved sutures and needles make it possible for patients to be out of bed the same day or next day. One surgeon in another state does this operation in a clinic and sends patients to a motel.

There has been recent publicity about a different way of doing the older extracapsular operation by aspirating part of the cataract through a needle. Aspiration of soft cataracts through a needle has been done for many years but has the disadvantage of leaving the capsule part of the cataract in the pupil.

A new and experimental method of making all cataracts soft and then removing the soft part with a needle has received publicity that is difficult for the public to evaluate. The incision is smaller but a stitch is still needed to close the surgical wound in the eye. The capsule is left in the pupil as in the older extracapsular operations. Complications are increased and the risk of loss of the eye is greater. The great medical research centers in this country do not use this experimental modification of the older operation. The public is advised to follow the advice of their own eye surgeon (ophthalmologist) and to resist the temptation to take a chance on something that is still an experiment.



We've Traveled Far—But Now, Quo Vadis?

If the medical profession were in the business of building healthy space ships, what recognition would have come to the builder of Explorer 1? What punishment to the builder of Apollo 13?

Explorer 1, you may remember, was our first satellite in space. It blasted off the launching pad at Cape Canaveral, Fla., Jan. 31st, 1958. It circled the globe for a dozen years, returning to burn up in the earth's atmosphere on the last day of March, 1970, amid the plaudits of three men primarily responsible for it—Dr. Wernher von Braun, Dr. William H. Pickering, and Dr. James A. Van Allen.

Said Von Braun: "Explorer 1 was a feeble, first step in space. But in its day it was an astounding accomplishment, done on short notice to place the free world in the space race."

Said Pickering, Director of the Jet Propulsion Laboratory, Pasadena, Calif.: "When Explorer 1 was launched in 1958, our very real concern was in obtaining an orbit that would last at least a few weeks . . . Now 12 years later, we cannot help feeling a little sad that our first satellite which lasted beyond all expectations has finally come back to earth."

Said Dr. Van Allen: "Its successful orbiting is one of the landmarks in the technical and scientific history of the human race. Its instrumentation revealed the existence of the radiation belts around the Earth and opened a massive new field of scientific exploration in space."

Before taking its final and flaming plunge, the 30.8-pound satellite had chased itself around the world 58,000 times!

But what of moonbound Apollo 13, which came to grief on April 13, a scant two days after quitting its launching pad in the same vicinity as its distant forebear?

Supposing medical science instead of related sciences had been responsible for the two of them, accountable to whatever powers there be for the success of one, the failure of the other.

There can be little doubt that the master builders, who plunged us late but eager into the space race with the Soviet Union, were doing their dead-level best. Nor can there be any doubt that those surgeons who brought us from behind the Union of South Africa doctor into the forefront of heart transplants were dedicated to success.

There are two kinds of builders: those

who build from established patterns, responsible to precedent, and those who combine schooling, ingenuity and courage to build where none has built before. Those who build schools and bridges, patterned automobiles and airplanes are accountable.

But what of those who challenge eternity with a scalpel or infinity with a space ship? If they too are held accountable, will the day come when there will be no more builders of space ships? No more doctors of medicine?

Already the supply is shriveling, not because the qualification standards are too high, eliminating a host of possibles, but rather because so many of those who could qualify have turned from medicine to less endangered areas of activity.

Where do we go from here?

And Now MASA Looks Ahead To 110th Annual Session

The nation's third oldest city, the "Mother of Mystics," hosted when the 109th annual session of the Medical Association of the State of Alabama was held in Mobile.

Birmingham, the largest and youngest city in the State, is next in the quadrennial line as MASA's convention scene next spring.

In the course of the Mobile meeting, which brought in noted personalities from over the nation to participate, and which agreeably sandwiched gay social events between business and scientific sessions, Dr. S. Buford Word of Birmingham succeeded Dr. C. Kermit Pitt of Decatur as President, while Dr. A. E. Thomas of Montgomery was chosen President-elect. Dr. Henry Gunter Hodo, Jr., of Fayette was elected to the Board of Censors, succeeding Dr. Hugh E. Gray of Anniston, while Dr. Ira B. Patton, Oneonta, succeeded Dr. Hodo on the Board of Trustees.

Two out-of-state physicians prominent in medicine's political history were featured speakers at the annual meeting, along with the Governor of Alabama. Both were obtained by ALAPAC and both were accompanied to Mobile by their charming wives. It was all four's first visit to the Deep South.

Otis R. Bowen, M.D., currently Speaker of the House of Representatives of the State of Indiana, was featured on the largely attended Orientation Program on Thursday morning. His subject: "Take the Time, Make the Effort." The Bowens live in Bremen, Ind., where he is in General Practice.

G. Robert Bartron, M.D., of Watertown, S.D., currently President Pro Tempore of the South Dakota Senate, and considered a very probable Republican candidate for Lieutenant Governor of his native State in 1972, spoke before the Awards Dinner Friday night.

Because of a foul-up in the schedules of Gov. Albert Brewer, the Governor and Dr. Bartron swapped places on the speaking program, and Alabama's Chief Executive spoke before the annual luncheon Friday, May 1, of the Alabama Medical Political Action Committee. So much of Dr. Bartron's speech revolved around the substance of his original subject: "The Physician, Politics and Prestige."

More than 300 guests attended the ALAPAC luncheon and heard Gov. Brewer speak on the importance of political involvement. He was introduced by Dr. C. Kermit Pitt of Decatur, MASA President. Dr. Grover C. Murchison, Jr., of Montgomery, ALAPAC board chairman, presided as master of ceremonies and introduced notables at the speakers' tables, including Dr. Gerald D. Dorman, AMA President; Dr. and Mrs. John M. Chenault, one chairman of the State Board of Censors, the other President of the Womans Auxiliary of the American Medical Association; Drs. Bowen and Bartron, and others.

The Auxiliary luncheon was also a notable

success, with the Rev. Father Daniel Egan, New York City, as the principal speaker. Mrs. Ben H. Johnson, Jr., WAMASA President, presided.

A camera report of the always important Awards Dinner Friday night, May 1, appeared in the May issue of the Journal.

The Gaslight Party of Thursday night featured talented Woman's Auxiliary teams from Alabama's major cities.

In-state and out-of-state doctors divided responsibility for the three superb Scientific Sessions:—Dr. Dorman from New York and Dr. S. Richardson Hill, Jr., Birmingham, vice president for Health Affairs, University of Alabama School of Medicine; Dr. Claude Frazier, Asheville, N.C., and Dr. Charles E. Flowers, Jr., Alabama School of Medicine, Birmingham; Dr. Eugene A. Stead, Jr., Durham, N. C., Duke Professor of Medicine, and Dr. W. A. Daniel, Jr., Birmingham, Alabama Professor of Pediatrics; and Drs. Richard T. Smith, Gainesville, Fla.; W. Sterling Edwards III, Albuquerque, N.M.; Denton A. Cooley, Houston, Texas; Max D. Cooper, Alabama School of Medicine; Richard G. Lester, Duke; and Mr. Ronald C. Merrell, Medical student, Birmingham.

Other speakers through the 109th annual session of MASA included Mrs. Chenault, U. S. Appeals Court Judge Walter P. Gewin, Tuscaloosa; Drs. William T. Wright, Mobile; Joseph H. Sugg, Birmingham; Ira L. Myers, State Health Officer, Montgomery; Clifton K. Meador, Birmingham; John W. Benton, Birmingham; E. W. Stevenson, Birmingham, who made the Awards presentations; Richard F. Bliss, Talladega, ALAPAC Board member; and invocations were given by: Joel D. McDavid, D.D., Dauphin Way United Methodist Church; Massey M. Heltzel, D.D., Government Street Presbyterian Church; and the Most Rev. John L. May, Bishop, Mobile Diocese Catholic Church, all of Mobile.

Fifteen past presidents were introduced at the Awards Dinner: Drs. E. L. McCafferty, E. Bryce Robinson, J. O. Finney, James G. Donald, E. B. Glenn, James G. Daves, M. Vaun Adams, John W. Simpson, Hugh E. Gray, William R. Carter, Edgar G. Givhan, Jr., John A. Martin, Grady O. Segrest, J. Orville Morgan, B. W. McNease. And the names of 10 new memberships in the 50-Year Club, most of whom were present, were read: Drs. James G. Daves, Herbert B. Dowling, Jr., William E. McGrath, James L. Taylor, William G. Thuss, Henry O. Walker, Maurice S. Whiteside, Frank C. Wilson, Gerald G. Woodruff, Lewis G. Woodson, Jr.

And finally, thumbnail sketches of MASA's new President, President-elect, member of the Board of Censors, and member of the Board of Trustees:

Born in Aberdeen, Miss., Dec. 21, 1907, S. Buford Word received his baccalaureate degree from Birmingham-Southern in 1931, his M.D. from Louisiana State in 1935, and his hospital training at Charity Hospital, New Orleans. He was in private practice in Birmingham from 1937 to 1940, in the Army Medical Corps to 1946, and then returned to private practice in Birmingham, in Obstetrics and Gynecology. The new President of the Medical Society of the State of Alabama is married to the former Sylvia Riley and they have six children.

MASA President-elect Archie Edwin Thomas, M. D., was born at Nixburg, Ala., in 1898, received his early education in the public schools of Jacksonville, Ala., and Akron, Ohio; studied pre-medicine at Auburn, and received his M. D. at Vanderbilt in 1924. He interned at T.C.I., Fairfield, and at Walter Reed, Washington. He practiced five years in Birmingham before going on for special training in two Chicago hospitals, then resuming practice in Montgomery, specializing in Obstetrics and Gynecology. Dr. Thomas was married to Victoria Acuff of Jasper, Ala., in 1924 and they have one son, James E. Thomas.

Henry Gunter Hodo, Jr., was born in Millport, Ala., Jan. 28, 1915, attending the public

(Continued on Page 1089)

Schering

After only one year:

Administered to more people than live in Montgomery and Gadsden.*



Injectable
Garamycin®
brand of
gentamicin sulfate injection

*An estimated 208,000 patients have received GARAMYCIN Injectable to date. The combined population of Montgomery and Gadsden is 205,000. (Estimated 1969 figures from The New York Times Encyclopedic Almanac 1970.)

See Clinical Considerations section on last page...

Mounting acceptance in the hospital...

Proven clinical effectiveness



Respiratory Infections

Outstanding results in serious gram-negative respiratory infections[1,2]

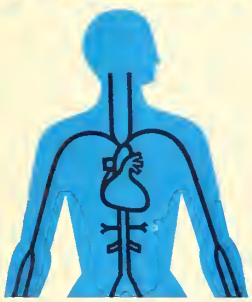
GARAMYCIN Injectable may prove successful where other antibiotics have failed.



Urinary Tract Infections

Strikingly effective in selected urinary tract infections[3]

With relatively low intramuscular doses, the promptly attained levels of GARAMYCIN achieved in the urine are considerably higher than the concentrations required for effectiveness against virtually all susceptible gram-negative pathogens. (Appropriate precautions are indicated in patients with impaired renal function; consult Package Insert for full details.)



Septicemia

May be lifesaving[4-6]

Numerous investigators have drawn attention to the value of GARAMYCIN Injectable in the treatment of gram-negative septicemias, often complicated by shock. Many hospital strains of *Serratia* are susceptible.[6]



Wounds and Burns

Response may be dramatic in wounds and burns complicated by sepsis[7]

The established efficacy of GARAMYCIN Injectable against *Pseudomonas*—as well as most other gram-negative pathogens—makes it an especially useful agent in the treatment of infected wounds and burns.

Important Precautionary Note Patients receiving treatment with GARAMYCIN Injectable (gentamicin sulfate injection) should be under close clinical observation because of the toxicity associated with the use of the drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with preexisting renal damage, treated with GARAMYCIN Injectable for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with preexisting renal damage.

This drug should be limited to the treatment of serious infections caused by susceptible gram-negative bacteria, with due regard for relative antibiotic toxicity. (See Clinical Considerations section.)

Mounting evidence in the laboratory...

Schering

Over 95% gram-negative pathogens sensitive.*

No other antibiotic performed comparably *in vitro* against gram-negative pathogens.
In a nationwide culture audit of antibiotic sensitivity patterns, sensitivity reports from 106 hospitals, geographically representative by census tract and of varying sizes, were analyzed. During the three-month period, ***every*** gram-negative culture slip from ***every*** hospital was surveyed. The total number of cultures involved in the audit was 97,091. The total number of sensitivity determinations was 643,503.

Pathogens	Percentage of sensitive strains / Number of strains tested — Antibiotics*							
	Garamycin	Kanamycin	Cephalothin	Cephaloridine	Ampicillin	Colistimethate	Chloramphenicol	Tetracycline
Klebsiella pneumoniae	99.5% 962	84.7% 992	86.2% 995	76.1% 67	32.7% 1,020	96.3% 640	82.9% 1,028	77.1% 1,026
Aerobacter aerogenes	95.9% 2,739	86.1% 2,818	53.5% 2,985	58.8% 1,514	22.7% 3,066	88.6% 2,603	85.8% 3,071	67.8% 2,981
Klebsiella aerobacter group	98.8% 566	83.9% 547	66.1% 522	60.5% 276	28.0% 553	89.5% 560	86.2% 587	62.8% 433
Klebsiella, all others	92.7% 2,944	83.3% 3,186	77.4% 2,976	67.5% 627	13.5% 2,883	95.0% 2,105	81.6% 3,212	70.6% 3,063
Pseudomonas aeruginosa	91.6% 4,528	29.8% 4,460	6.6% 4,418	6.6% 1,279	6.0% 4,360	91.3% 3,852	26.9% 4,608	26.4% 4,404
Proteus, indole-positive	91.8% 1,031	85.8% 1,062	39.9% 981	54.1% 364	40.2% 1,042	10.3% 758	76.1% 1,096	42.1% 1,051
Proteus mirabilis, indole-negative	94.9% 3,272	90.1% 3,378	83.1% 3,290	77.5% 975	78.0% 3,274	8.8% 2,634	85.9% 3,469	26.8% 3,278
Proteus, unspecified	96.2% 1,335	85.8% 1,371	71.7% 1,434	70.0% 647	64.7% 1,435	11.2% 1,233	76.0% 1,421	22.4% 1,298
Escherichia coli and all other *Escherichias*	96.4% 12,557	91.4% 12,818	87.8% 12,686	88.8% 4,251	74.6% 12,899	95.4% 10,623	94.1% 13,086	70.0% 12,559
Paracolobactrum, all	93.4% 303	88.9% 325	62.0% 305	74.2% 62	43.8% 340	80.9% 215	87.1% 350	72.6% 340
Coliform bacteria	99.0% 593	91.2% 649	81.5% 637	66.7% 21	52.7% 624	95.6% 607	91.6% 678	76.1% 637
Totals	95.1% 30,830	80.5% 31,606	65.3% 31,229	68.1% 10,083	50.3% 31,496	75.8% 25,829	79.7% 32,606	56.5% 31,070
Gram-positive (included for consistency with Package Insert, not an approved indication)								
Staph—*S. aureus,* coagulase-positive	97.4% 1,548	88.8% 1,458	97.7% 2,050	98.7% 636	61.1% 1,559	20.4% 628	94.4% 2,123	83.7% 1,966
Staph—*S. aureus,* unspecified	99.3% 993	92.8% 902	98.1% 1,289	95.3% 213	45.8% 1,153	29.3% 116	96.4% 1,427	82.3% 1,360

*Adapted from a three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August, 1969).[5]
Antibiotics with significant gram-negative spectra are included. Organisms are listed as reported by laboratory.
Sensitivity testing was done by the disc method, a generally reliable test in the hospital setting. It should be noted, however, that the results with GARAMYCIN were somewhat higher than the results reported where the tube dilution technique was used. (See Clinical Considerations section which follows.) The concentration of the GARAMYCIN disc was 10 mcg.
Whereas standard testing methods were used by all hospitals, it is acknowledged that in a survey of this kind considerations such as differences in methodology are possible sources of error. The comparative percentage-sensitivity results derived from a survey of this kind are, therefore, not absolute. One should keep in mind also that the proper selection of an antibiotic is based not only on susceptibility testing but on relative toxicity and other clinical considerations as well.
It is felt, nonetheless, that the broad scope of the survey and the extreme care in data collection and tabulation permit a conclusion that the results are *generally* representative of current nationwide antibiotic sensitivity patterns.

Injectable Garamycin®
brand of gentamicin sulfate injection

See Clinical Considerations section on last page...

Injectable Garamycin®

brand of gentamicin sulfate injection

ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
	Less Severe	**Resistant/ Moderately Severe**	**Serious/Life-Threatening**
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	0.8-1.2 mg./kg. for 7-10 days	Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	up to 5 mg./kg.
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those wit pre-existing renal damage, treated with GARAMYCIN Injectabl usually for longer periods or with higher doses than recommende

GARAMYCIN Injectable is potentially nephrotoxic, and thi should be kept in mind when it is used in patients with pre-existin renal impairment. Kidney function diminished by infection of th upper urinary tract may, however, improve during effective trea ment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such a streptomycin and kanamycin or of potentially nephrotoxic dru such as polymyxin, colistin, and kanamycin with gentamicin sulfa has not been shown to afford any clinical advantages and, moreov may result in additive toxicity. Monitoring of vestibular, cochlea and renal function will provide guidance for therapy in such case

Precautions: In patients with impaired renal function in who serious infection develops, serum concentrations of the drug ma rise, with consequently increased risk of ototoxicity. In these p tients or in those in whom recommended dosage or duration therapy must be exceeded as a life-saving measure, routine studi of kidney function should be performed when possible. These m be supplemented by evaluation of the vestibular and auditory fun tion and measurement of serum concentration of the drug wh feasible. Serum concentrations of gentamicin should be maintain below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to days or be repeated unless required for serious infection not r sponsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectal may occasionally result in overgrowth of nonsensitive organisms. superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity nephrotoxicity have not been established. Studies in pregnant a mals have not revealed teratogenic or ototoxic effects in the fet GARAMYCIN Injectable should not be used in pregnant patients in women of childbearing age unless its use is deemed advisal by the physician.

Adverse Reactions: The overall incidence of ototoxicity consider related to treatment with GARAMYCIN Injectable was 2.8 per c (16 of 565 patients). Contributory factors (two or more factors w relevant to most patients) were as follows: 10 had azotemia, received a total of 1 gram or more of the drug, 7 had recently ceived other potentially ototoxic antibiotics (streptomycin or ka mycin), and 5 were over 60 years of age. Six also had decrea high-tone hearing acuity, which returned to or toward normal the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients sho increases in BUN that were probably related to treatment w GARAMYCIN Injectable. Of 20 increases probably or possibly rela to treatment, 7 were reversible, 9 occurred in terminal patients, 4 had no follow-up.

Other adverse reactions associated with treatment were one insta each of urticaria, decreased hematocrit, and reversible depress of granulocytes with normal bone marrow. Other rarely repo and possibly treatment-related adverse reactions were anemia, creased reticulocyte count, rash, purpura, drug fever, hypotens convulsions, twitching, salivation, nausea, vomiting, increased tr aminase activity (SGOT or SGPT), increased serum bilirubin, creased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple- vials, for intramuscular administration.

References: (1) Brayton, R. G., and Louria, D. B.: Gentamici gram-negative urinary and pulmonary infections, Arch. Int. M *114*:205, 1964.* (2) Louria, D. B.; Young, L.; Armstrong, D., Smith, J. K.: Gentamicin in the treatment of pulmonary infecti J. Infect. Dis. *119*:483, 1969. (3) Cox, C. E.: Gentamicin, a aminoglycoside antibiotic: Clinical and laboratory studies in uri tract infections, J. Infect. Dis. *119*:486, 1969. (4) Groll, E.: Cli experience with gentamicin, data from 12 German clinics, in tamicin: First International Symposium, Paris, January Lucerne, Essex Chemie AG, pp. 121-128.* (5) Jackson, G. G.: La tory and clinical investigation of gentamicin, *ibid.*, pp. 62-74 Medeiros, A. E.: Discussion, J. Infect. Dis. *119*:533, 1969. (7) Polk Discussion, J. Infect. Dis. *119*:529, 1969. (8) Three-month, nation hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachu (mid-May to mid-August, 1969).

*Dosage in this investigational study was less than now recomme in Package Insert.

For more complete prescribing details, consult package inse Physicians' Desk Reference. Schering literature is also avai from your Schering Representative or Medical Services Depart Schering Corporation, Union, New Jersey 07083.

AHFS CATEGORY 8:12.28

(Continued from Page 1084)

schools there before going to the University of Alabama for his baccalaureate degree. He earned his M.D. degree from the University of Pennsylvania in 1940, was a resident in surgery at Hillman to 1944, and served with the U.S. Army in Italy, North Africa, and the Philippines, 1944-46, when he began practice in Fayette. He has served as a Vice President of MASA, served two terms on its Board of Trustees, was the first chairman of the AMA-ERF Committee, and filled other offices before being elevated to the Board of Censors. Dr. Hodo is married to the former Naomi Brock of Fayette and they have one son, Henry Gunter Hodo III.

Dr. Ira Bertling Patton, the newest member of the Board of Trustees of the Medical Association of Alabama, was born May 24, 1923, in Birmingham, attended Woodlawn High School, received his baccalaureate from Howard, and his M.D. degree from Alabama. In General Practice and Surgery in Oneonta, he is one of the original members of the Hospital Medical Council, and served as chairman of the Subcommittee on Awards of the Public Relations Committee before becoming Public Relations chairman last year. Dr. Patton is married to the former Darlene Franklin of Birmingham, and they have four sons, one of whom is pursuing a medical education, and two others presently plan to follow in their father's footsteps.

Mike, eldest of the four Patton sons, has completed his education and entered the business world, but the second son, David, will be a senior in pre-medicine at Auburn next year. Steve, who overcame a childhood attack of rheumatic fever to become a football player, and Jim Patton are both still in high school, but both plan to enter the field of medicine.

Attendance at the Mobile meeting was 901, which was below the average for the last 12 years, but comfortably ahead of each decade-turn from 1930 (609), 1940 (841), 1950 (711), and 1960 (826).

—W. J. M., Jr.

Birth Defects Symposium

"Disorders of Glucose Metabolism in Children," the second annual Birth Defects Symposium, will be Oct. 30-31, 1970, at the University of Florida College of Medicine, Gainesville. Sponsored by the university's Institutional Division of Endocrinology and Metabolism and the National Foundation—March of Dimes Birth Defects Center, the symposium will feature discussions of diabetes mellitus, hypoglycemias of childhood and energy metabolism, as well as case presentations. Guest faculty are Allan Drash, M.D., Associate Professor of Pediatrics, University of Pittsburgh, and Donough O'Brien, M.D., Professor of Pediatrics, University of Colorado. Dr. Arlan L. Rosenbloom, Assistant Professor of Pediatrics and director of UF's Birth Defects Center, is program director; meetings will be held in the second floor auditorium of the College of Medicine.

Registration fees will be waived for interns and residents. For additional information and schedule of fees, please write Mrs. Betty L. Howard, Division of Postgraduate Education, J. Hillis Miller Health Center, Gainesville, Fla. 32601.

Are You A Drug Addict?

Says a recent biography of Madame de Maintenon: ". . . West Indies land owners hoped to enrich themselves by exporting to France cotton and the new and exciting *drug*, tobacco, which was fetching the high price of such a luxury commodity."

Says Funk & Wagnalls: "A *drug* is . . . any substance or chemical agent, exclusive of food, employed for other than medical reasons to obtain a physiological effect or to satisfy a craving."

Says Funk & Wagnalls: "A *drug addict* is one addicted to a habit-forming drug."

Ergo, smoking is a drug addiction.

Legal Page:

Legal Problems In Medical Practice Partnerships

J. Jerry Wood, J. D.

Many physicians enter into partnership agreements and arrangements with the blissful thought that no problems will arise between the partners. Sometimes these medical partnership agreements are entered into without any written agreement or without any clear understanding about such matters as division of partnership practice proceeds, ownership of medical records, rent on equipment owned by one partner, or a clear understanding of rent and expenses on office facilities owned by one partner.

Bernard D. Hirsh, Director of the AMA Law Division, has pointed out that there are pros and cons to partnership practice and offers this advice in *Business Management of a Medical Practice:*

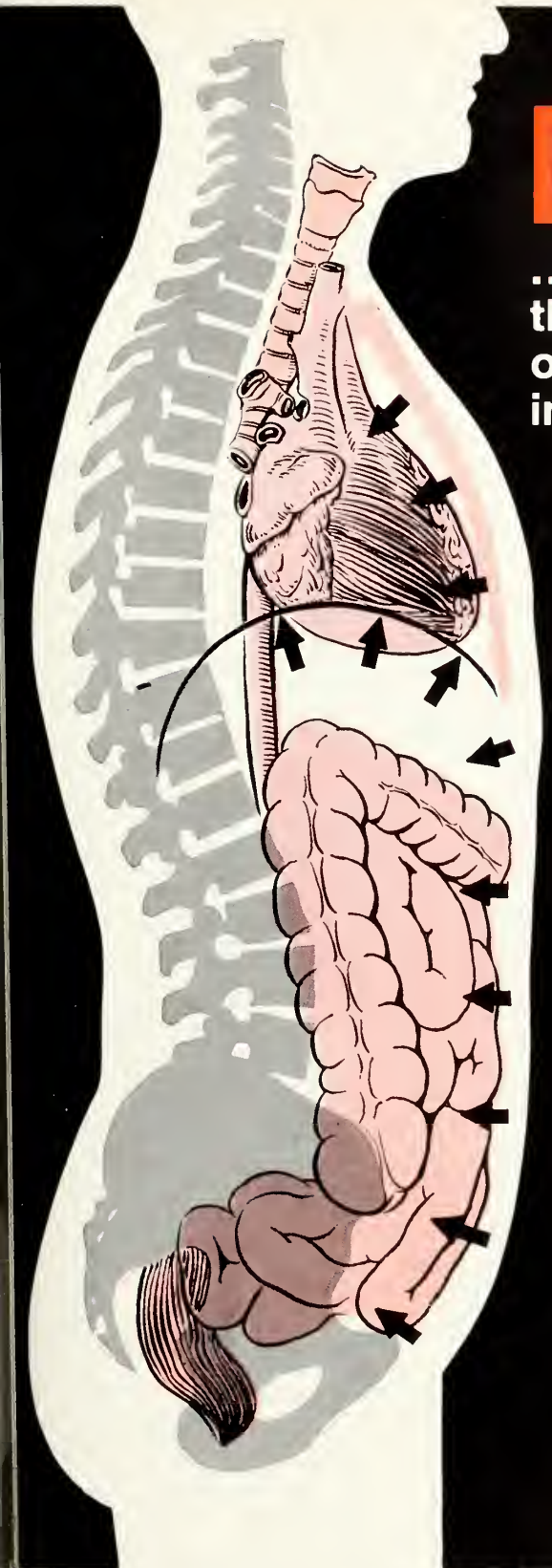
> "The best reason for a medical partnership is the desire to combine professional resources and talents for the most effective practice of medicine . . . The success of a partnership will depend upon the professional and personal compatibility of its members . . . Prospective partners should know each other and be exposed to each other's idiosyncrasies for a long time before considering partnership (St. Louis: C. V. Mosby Co., 1964)."

Especially important, no matter how well the partners know each other, is the partnership agreement. Obviously, an attorney should be consulted for advice and guidance. Careful thought must be given to the ownership of assets, capital, division of income, disability of partners, military service leaves of absence, expulsion of partners, ownership of medical records upon dissolution and perhaps even an agreement to be bound by compulsory arbitration should disputes arise.

Prospective partners should be represented by individual attorneys when the formal partnership agreement is drafted. Periodic reviews of the partnership agreement should be made so that it can be updated to best serve the needs of the partners and modified for the more effective practice of medicine by the partners with their specialized interests and knowledge.

Many Alabama physicians are presently practicing in partnerships without any formal partnership agreement. When disputes do arise in these partnership arrangements, hours are wasted on negotiations for patient records, final settlement of accounts receivable, and in disputes over whether the withdrawing partner or partners should practice in the immediate area. These are matters that can be properly and carefully covered at the inception with a carefully drafted partnership agreement.

While model partnership agreements are available from the AMA and from the MASA central office, it is important for physicians to involve local attorneys in order to be sure that the document is customized to the particular partnership situation. Partners presently in practice without a clear understanding of their partnership situation should review this with the partners involved and amicably clarify areas where disputes may arise before they do so. Such a review may preclude bruised feelings and prevent needless litigation.



DOXIDAN®

...to reduce the hemodynamic "bind" of constipation in congestive heart failure

Constipation in the chronic heart failure patient carries with it the ever-present threat of acute cardiac decompensation while straining at stool. In the already weakened, distended heart, a sudden influx of blood on termination of the Valsalva maneuver is considered to be the mechanism of some of the deaths occurring in these cardiac patients during straining efforts.*



Doxidan is a gentle laxative designed to free your patient from the hemodynamic consequences of straining at stool. With a fecal softening agent to keep the stool soft and easy to evacuate, and with just enough peristaltic stimulation to urge the sluggish bowel, Doxidan reduces the hemodynamic "bind" of constipation.

Composition: Each capsule contains 50 mg. danthron N.F. and 60 mg. dioctyl calcium sulfosuccinate.

Dosage: Adults and children over 12—one or two capsules daily. Children 6 to 12—one capsule daily. Give at bedtime for two or three days or until bowel movements are normal.

Supplied: Bottles of 30, 100 (FSN 6505-074-3169) and 1000 (FSN 6505-890-1247).

*st, C. H. and Taylor, N. B.: *The Physiologi- al Basis of Medical Practice*, 7th edition, lliams and Wilkins, Baltimore, 1961, p. 480.

DOXIDAN®

HOECHST
PHARMACEUTICAL CO.
Div. American Hoechst Corp.
Cincinnati, Ohio 45229 U.S.A.

C-124


Pfizer
100
rap
absorptio
may surpa
tetracycli
I.M. blo
levels with
one ho
real broad spectrum,
including
susceptible strains of
Pneumococcus*
"Staph"* "Strep"*
H. influenzae*
M. pneumoniae (PPLO)*
N. gonorrhoeae*
low incidence
of diarrhea
outstanding record
of clinical success
therapeutic blood levels
usually persisting
around-the-clock
24



high tissue levels

unlike other tetracyclines can be given with milk or meals

The effectiveness you need. The advantages you look for.

Vibramycin® (doxycycline)

a semi-synthetic tetracycline

*Because not all strains of pathogens are susceptible, it is recommended that routine culture and susceptibility studies be performed. When using Vibramycin (doxycycline) in streptococcal infections, therapy should be continued for 10 days to prevent the development of rheumatic fever or glomerulonephritis.

See Brief Summary on next page for information on side effects and contraindications.

Pfizer LABORATORIES DIVISION
New York, N.Y. 10017



and convenience too.



The unique new Vibramycin (doxycycline) V-Pak is especially convenient for use both in your office practice and in the hospital outpatient department. It contains a typical four-day course of therapy for routine infections with easy-to-understand patient instructions. The dosage is low, just 100 mg. b.i.d. the first day followed by 100 mg. once a day for the next three days. In more severe infections, 100 mg. q.12 h. is recommended. If renal impairment exists, lower than usual doses are indicated.

And for added convenience in the hospital pharmacy, Vibramycin is available in unit-dose packs of 100 (10 x 10's) for both the 100 mg. and the 50 mg. capsules.

VIBRAMYCIN® (doxycycline)
BRIEF SUMMARY

Contraindicated: In individuals who have shown hypersensitivity to doxycycline.

Warnings: The usual dosage and frequency of administration of Vibramycin (doxycycline) differs from those of other tetracyclines. Exceeding the recommended dosage may result in an increased incidence of side effects.

If renal impairment exists, even usual doses may lead to excessive accumulation of the drug and possible hepatic toxicity. For such patients, lower than usual doses are indicated and, if treatment is prolonged, Vibramycin serum level determinations may be advisable.

Vibramycin, like other tetracyclines, may form a stable calcium complex in any bone-forming tissue, although *in vitro* Vibramycin binds calcium less strongly than other tetracyclines. The use of Vibramycin during tooth development (last trimester of pregnancy, neonatal period, and early childhood) may cause discoloration of the teeth (yellow-gray-brownish). This effect may occur mostly during long-term use, but also may occur with short-treatment courses.

Increased intracranial pressure with bulging fontanelles has been observed in infants receiving tetracyclines. This effect has disappeared rapidly on cessation of therapy with no sequelae.

In certain hypersensitive individuals treated with Vibramycin, exposure to direct sunlight may precipitate a photodynamic reaction. In individuals with a history of photoallergic reactions to tetracyclines, exposure to direct sunlight should be avoided and treatment should be discontinued at first evidence of skin discomfort.

Precautions: As with any antibiotic, overgrowth of nonsusceptible organisms may occasionally occur. Constant observation of the patient is essential. If such superinfections are encountered, Vibramycin should be discontinued and replaced by appropriate therapy.

When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be utilized. In all cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months.

Adverse Reactions: Nausea, vomiting, diarrhea, vaginitis, as well as reactions of an allergic nature such as dermatitis, urticaria, and anaphylaxis may occur but are rare. Glossitis, stomatitis, proctitis, onycholysis and discoloration of the nails may rarely occur during tetracycline therapy as with other antibiotics. If severe adverse reactions, individual idiosyncrasy, or allergy occur, discontinue medication.

As with other tetracyclines, elevation of SGOT or SGPT values, or elevated BUN have been reported, the significance of which is not known at this time. Anemia, neutropenia, and eosinophilia have been reported, as with other tetracyclines.

Animal Pharmacology: As with other tetracyclines, at doses greater than those recommended for human usage, Vibramycin produces discoloration of animal thyroid glands. Careful monitoring of animals and humans has disclosed no abnormalities of thyroid function studies. Also, as with other tetracyclines, at relatively high oral doses, evidence of hepatotoxicity has been noted in dogs and signs of gastrointestinal intolerance have been seen in both dogs and monkeys.

Dosage: The usual dose of Vibramycin is 200 mg. on the first day of treatment (administered 100 mg. every 12 hours) followed by a maintenance dose of 100 mg./day. The maintenance dose may be administered as a single dose, or as 50 mg. every 12 hours. In the management of more severe infections (particularly chronic infections of the urinary tract), 100 mg. every 12 hours is recommended. The recommended dosage schedule for children weighing 100 pounds or less is 2 mg./lb. of body weight divided into two doses on the first day of treatment, followed by 1 mg./lb. of body weight given as a single daily dose or divided into doses, on subsequent days. For more severe infections up to 2 mg./lb. of body weight may be used. For children over 100 lbs. the usual adult dose should be used.

Acute gonococcal anterior urethritis in male —a single dose of 300 mg. or 100 mg. b.i.d. for 2-4 days.

Acute gonococcal infections in the adult female should be treated with doses of 100 mg. b.i.d. until cure is effected.

Therapy should be continued beyond the time that symptoms and fever have subsided. When used in streptococcal infections, therapy should be continued for 10 days to prevent the development of rheumatic fever or glomerulonephritis.

If gastric irritation occurs, it is recommended that Vibramycin be given with food or milk. Studies indicate that the absorption of Vibramycin is not markedly influenced by simultaneous ingestion of food or milk.

Simultaneous administration of aluminum hydroxide gel given with tetracycline antibiotics including Vibramycin has been shown to decrease absorption.

Supply: Vibramycin Hyclate (doxycycline hyclate) is available as capsules containing doxycycline hyclate equivalent to 50 mg. of doxycycline, bottles of 50, unit-dose pack of 100 (10 x 10's), and X pack of 50 (5 x 10's) capsules containing doxycycline hyclate equivalent to 100 mg. of doxycycline, bottles of 50, unit-dose pack of 100 (10 x 1 and V pack of 25 (5 x 5's).

Vibramycin Monohydrate (doxycycline monohydrate) is available as a dry powder for oral suspension containing when reconstituted doxycycline monohydrate equivalent to 25 of doxycycline per 5 cc. (each teaspoonful with a pleasant-tasting raspberry flavor, 2 bottles.

More detailed professional information available on request.

Pfizer LABORATORIES DIVISION
New York, N.Y. 10017

Vibramycin®
(doxycycline)
a semi-synthetic tetracycline

Malpractice and Basic Legal Principles

Julian B. McDonnell, Jr.

Assistant Dean, University of Alabama

School of Law

This subject focuses unavoidably on a new development which is placing considerable strain on the relationship between the medical and legal professions. There have, of course, been antagonisms before, but new concern and new emotion is now arising due to the recent rapid increase in the number of medical malpractice suits. Claims against doctors and hospitals are now being filed at an estimated rate of 10,000 a year. The AMA reports that one out of every six physicians practicing today has been confronted with at least one malpractice claim. In California—our most litigious state—the ratio is one out of every four doctors with a ten fold jump in the number of claims over a recent ten year span. Estimates are that the average amount of a medical malpractice judgment in 1970 will be $65,000. A recent study by the Senate Subcommittee on Executive Reorganization chaired by Senator Ribicoff concluded that the malpractice situation threatens to become "a national crisis."

It is difficult to isolate the causes of this crisis; certainly one cannot exonerate the legal system from culpability. But I suspect that the factors responsible for the mushrooming of malpractice litigation are multiple. My list would include:

—the retention of the lay jury as judges of professional conduct;

—the shortage of medical personnel;

—the increased complexity and potential of modern medical services with an attendant increase patient expectations and depersonalization of care.

—the general urban fragmentation of our society.

If this list is anywhere close to the mark, it will be very difficult, if not impossible, to strike at the underlying causes of the problem. Thus, doctors are caught in between: on the one hand threatened by suit and on the other hand unwilling defensively to modify procedures to reduce their legal exposure. The premise of this paper is that there is a middle way out that offers the promise of at least partial relief—that with a precise understanding of legal requirements intelligent precautions can often be taken that are wholly consistent with providing the best medical care. Accordingly, I would like to try to spell out the over-all objectives and the concrete doctrine of medical malpractice.

Law, of course, is supposed to be value oriented. Its doctrine is formulated as a response to "felt social needs." In the area of medical law, it seeks an accomodation of four primary social values. These values are

—preservation of individual control over invasions of bodily integrity

—maintenance of high standards of medical care

—retention of freedom of action and dis-

A lecture on medical jurisprudence delivered on March 27, 1970 to medical students, interns, residents and faculty of the University of Alabama School of Medicine.

cretion for the doctor in trying to obtain the best medical results

—compensation for those injured by illegal conduct.

In its efforts to protect and affect an accommodation of these values, our legal system has developed a body of doctrine that exposes a physician to liability on two major grounds. One is negligence, or the failure of a doctor to exercise the care required of a physician in his particular circumstances. The second is battery, or unpermitted contact with the body of the patient. These are the two principal grounds on which malpractice actions are based. There are other less important theories upon which an action might be predicated such as fraud, violation of an express agreement or invasion of privacy. But the incidence of these sorts of claims is low—less than five per cent of the total. Negligence and battery are, from the physician's viewpoint, the real dangers and we will concentrate on them.

Taking negligence first, it may be helpful for me to give you a recent concrete factual setting. The patient suffered from back trouble. He was admitted to a hospital for removal of a ruptured disc and the fusion of two spinal vertebra. The defendant surgeon and an assistant were responsible for the spinal fusion portion of the procedure. The patient lay with a pillow under his hips to spread the vertebra in his lower spine, and sandbags under his shoulder to help hold him up. Shortly into the fusion procedure, the anesthetist was unable to record a blood pressure for the patient. She changed the type of anesthetic and reported the problem to the surgeon, who told her to commence a blood transfusion. Shortly thereafter, the pressure was 90 over 60 and the patient's pulse rate went up higher than his systolic blood pressure. The hospital anesthesiologist was summoned. The anesthesiologist arrived approximately 25 minutes after the original difficulties. He found that the pillow on which patient rested had "worked its way upward and was pressing on the lower abdomen." When he removed the pillow, the blood pressure went from undetectable to 160 over 90. Neither the defendant surgeon nor his assistant had checked the position of the pillow despite the serious drops in blood pressure, nor did the surgeon accompany the patient into the recovery room. The patient came out of the operation with severe brain damage apparently due to inadequate circulation during the operation. On this data the Alabama Supreme Court held last July that evidence of the surgeon's negligence during the operation was sufficient to allow the jury to consider that issue and perhaps find the surgeon liable. The Court opinion is noteworthy on several points:

1. The surgeon in this 1969 case was judged by the same legal standard of care first proclaimed by the Alabama Court in 1901. The standard is the degree of care and skill customary in the profession. Thus, the key evidence in this spinal fusion case was expert testimony that it was customary in operations of this type for the surgeon or his assistant to check the position of the pillow and customary for the surgeon to follow a patient with these distress symptoms into the recovery room.

2. Implicit in the court's opinion is the concept that a surgeon in charge of an operating procedure may be responsible for the negligence of those working under his direction. In this case the court apparently felt it irrelevant whether it was the immediate duty of the surgeon or his assistant to check the pillow's location.

3. The court was willing to consider the surgeon's failure to accompany the patient to the recovery room as reflecting on his probable conduct during the operation itself. This emphasis on the post-operative or post treatment aspect of medical care is not un-

(Continued on Page 1098)

for the debilitated geriatric patient



Berocca®

TABLETS
high potency B-complex and C
for nutritional support

AVAILABLE ONLY ON Rx

contains water-soluble vitamins only

b.i.d. dosage

good patient acceptance

no odor, and virtually no aftertaste

Each Berocca Tablet contains:

Thiamine mononitrate	15 mg
Riboflavin	15 mg
Pyridoxine HCl	5 mg
Niacinamide	100 mg
Calcium pantothenate	20 mg
Cyanocobalamin	5 mcg
Folic acid	0.5 mg
Ascorbic acid	500 mg

Usual dosage is one tablet b.i.d.

Indications: Nutritional supplementation in conditions in which water-soluble vitamins are required prophylactically or therapeutically.

Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B_{12}.

Dosage: 1 or 2 tablets daily, as indicated by clinical need.

Available: In bottles of 100.

ROCHE

Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

(Continued from Page 1096)

usual. In a number of Alabama cases, the alleged failure of the doctor to attend his patient after surgery or to provide the proper care after setting a fractured bone has served as the basis for a successful malpractice action. This seems to be one of the particularly sensitive areas possibly because it is possible to draw implications of callousness in such circumstances.

Perhaps it will help now if I go back and amplify somewhat on each of these important aspects: standard of care, responsibility for the conduct of others, and specific danger points where charges of negligence frequently arise.

A traditional statement of a doctor's duty of care would run something like this: A physician must bring to the service and exercise such reasonable care, diligence, and skill as physicians in the same general neighborhood and the same general line of practice ordinarily have and exercise in like cases. This duty exists only where the doctor has agreed to provide medical care, but once he has undertaken to do so it does not matter if he acts gratuitously or is paid by someone other than the patient. Unless he foolishly makes an express promise to provide a cure, a doctor under this standard is not a guarantor of good results. Negligence cannot normally be inferred from the fact that the patient suffered harm at some time in point after the treatment. For example, negligence is not established by the presence of a blood infection after the patient received an injection absent a showing that improper techniques or substances were used. Similarly, nerve damage after extraction of an imbedded wisdom tooth does not itself show negligence. Moreover, if there is disagreement in the profession as to the proper treatment, a doctor is not negligent in selecting one of the available options even though it is supported by a minority. For example, it has been held that where opthalmologists disagree as to the proper timing of a cataract operation a doctor cannot be held liable for recommending an early removal in accord with one school of thought. Finally, a doctor is liable for damages due to negligence only where there is evidence that his conduct was the most likely cause of the patient's injury. As phrased by the Alabama court: "there must be something more than a mere possibility among others—that the negligence complained of was the cause of the injury."

In several respects this doctrine concerning a doctor's duty of care places him in a more favorable position than the non-professional accused of negligence. For one thing, the standard of care is set by the locality in which the doctor practices. The physician in a rural setting is not expected to have the sophistication of one in a large city. According to the Alabama court the doctrine "makes a concession to physicians who have not the learning nor the advantages of observation and experience enjoyed by the most learned and advantageously situated of their professional brethren." In some states—though not in Alabama—courts are beginning to deemphasize the locality element of the standard on the grounds that the rural isolation which gave birth to it no longer exists.

The traditional doctrine is also more lenient than standard negligence law in specifying that observance of customary procedures is a complete defense to liability. In non-professional negligence cases, custom is treated as only one item for the jury to consider. It is conclusive in medical malpractice cases because the lay jury has no way to erect a standard of care based on its own experience. The practical consequence of this doctrine is that a malpractice action can seldom succeed without expert testimony that the defendant failed to exercise customary care. The claimant is normally unable to lay out the sequence of treatment and injury and claim that the facts speak for themselves. There are, however, two exceptional cases where jury is allowed to find negligence even without expert testimony. These are cases

(Continued on Page 1100)



The pain of arthritis

relieved with MEASURIN® q. 8h. dosage

Double-strength Measurin timed-release aspirin offers a new kind of control for your arthritic patients. Each 10-grain tablet has over 6,000 microscopic reservoirs that release aspirin at a controlled rate—some right away and some later on. This means—fast relief, followed by long lasting relief. Throughout the day, Measurin gives your patients freedom from a 4-hour dosage schedule. Measurin can help your patients get a good night's sleep, uninterrupted by the need for an extra dose of aspirin. And, taken at bedtime, it also helps ease morning joint discomfort and stiffness.

For Professional Samples write:
Breon Laboratories Inc.
Sample Fulfillment Division
P.O. Box 141
Purview, N.J. 07022

BREON LABORATORIES INC.
1 Park Avenue, New York, N.Y. 10016
A subsidiary of Sterling Drug Inc.

MEASURIN®
TIMED-RELEASE ASPIRIN
ECONOMICAL • EFFECTIVE • LONG LASTING PAIN RELIEF
Dosage: 2 tablets followed by 1 or 2 tablets every 8 hours as required, not to exceed 6 tablets in 24 hours. For maximum nighttime pain relief and to help relieve early morning stiffness, 2 tablets at bedtime.
Available: Bottles of 12, 36 and 60 tablets.

(Continued from Page 1098)

where foreign objects such as forceps, gauze, sponges or needles are left in the patient's body and where injuries to the body occur remote from the area of operation as with eye damage during an appendectomy. The surgeons lack of care is considered apparent in these situations.

With all of this emphasis on customary practice you may be worried about undue exposure for those who are leading the way in the development of new and improved techniques. This apprehension would undoubtedly be heightened if you read the rubric that courts often proclaim to the effect that "a doctor experiments at his own peril." If you examine the case law closly, however, you find this rubric is somewhat of an overstatement. Doctors have been held liable in these "new treatment" cases where they have resorted to a dangerous new approach without first demonstrating the ineffectiveness of a less risky traditional procedure, or where there was an obvious lack of proportion between the operational risk to the patient and the risk of allowing his condition to continue, or where they failed to fully explain to the patient the options available and risks of the new approach. In sum, it is not innovation itself but innovation under circumstances where it is not called for by the prudent practice of the profession that is condemned.

A greater danger than that associated with new techniques is the doctor's frequent responsibility for the actions of others. The basic rule of law is that a principal is responsible for the negligence of his servants or agents. Translated into the medical field this doctrine means that a doctor may be liable for the lack of care of the doctors, nurses and technician who assist him in treatment. The surgeon is in a particularly exposed position here. The courts have often said that the personnel who assist a surgeon in a operation become his "borrowed servants" while in the operating room even though they are hired and paid by the hospital. The rationale of the doctrine is that the surgeon has the right to control and direct all involved in the procedure. In the rhetoric of some more romantic courts, the surgeon stands as the "captain of the ship" responsible for the conduct of all his men. An example is a Pennsylvania decision which imposed liability on an obstetrician when an intern negligently administered silver nitrate to a newborn baby's eyes even though the obstetrician was fully occupied in trying to stop severe hemorraging of the mother. The decisions are not clear in this area, but hopefully the courts are moving towards a more realistic understanding of the complexity of modern surgical procedures and the necessity for each individual involved to concentrate on discrete portions of the operation. Presently, I would suggest that you ask two questions in assessing the extent to which you may be vicariously liable for the conduct of others. One is do I actually control and direct the conduct of this individual? If so, the monkey is sure to be on your back. The second question is what are my patient's expectations as to the extent that I will personally be responsible for his safety? This question is particularly relevant in assessing the extent to which you may rely on pretreatment examinations given by another. The Alabama Court has held that surgeon who was the head of a hospital was not exonerated in relying on an intern's preoperative examination before performing a tonsillectomy—at least not where a relative of the patient had specifically requested an examination by the surgeon. The opinion stated "the inquiry in each case involves the scope of the undertaking of a physician and surgeon when a patient comes to him to treat his ailment, having contractual relations with no one else." Likewise, a doctor directly employed by the patient who administers a dangerous drug relying on the recommendation of another physician does so at his own risk on the theory that the patient is entitled to judgment and skill of the physician he selects. On the other hand, it is clear that a physician who arranges for a substitute who is not his partner or agent and gives the sub-

stitute doctor full control and discretion over the case is not liable for the substitute's negligence. With the law standing as it does, one precaution that might be appropriate before advanced surgical procedures is to have the patient acknowledge that different personnel are responsible for particular aspects of the operation. This acknowledgement might be included on the consent form that the patient signs.

Already, I think I have touched on most of the danger points where charges of negligence are frequent. Among these are:

—post-operative care where deficiencies are exploitable as indicative of callousness

—the foreign-object cases where the jury is allowed to draw its own conclusion about the surgeon's lack of care

—and the surgical team quandry when the head man may be responsible for all involved.

So far, we have considered the first major heory of medical malpractice—negligence. I would like to turn now and take up the secnd major ground—battery. Although this heory has only lately received emphasis, he basic legal principles are clear. A physiian who operates on or otherwise has conact with a patient without proper authority ommits a battery. If the doctor proceeds vithout authority he is liable for resulting njuries even though he exercised due care n the treatment. Normally, authority to reat arises from the informed consent of ne patient, but this is not always the case. the patient is in an emergency condition ich that he cannot consent, the doctor is auorized to proceed with steps essential to reserve life or health. The law implies the atient's consent in such circumstances. In e case of a minor, the consent must norally come from a parent. The approval of e mother is sufficient in ordinary cases it where a serious operation is involved, nsent should be obtained from both parents time permits. If the minor is 15 or above, his approval should also be obtained. In the case of mentally incompetent patients, look to legally appointed guardian, spouse, or next of kin in that order for consent. Elemental prudence suggests that it is often wise to obtain a relative's consent even where it is not legally required as a technicality of law. A husband's consent to a serious operation on his wife is probably the most potent practical deterrent to malpractice claims available. Similarly, it is prudent to get a relative's approval in emergency cases where feasible. In this whole field of battery, in fact, the question is not what is the minimum that the law requires but what are the procedures likely to keep a doctor out of court. There are Alabama cases that indicate that a physician may rely on a patient's oral consent and that consent will be presumed where the patient knows that an operation is going to be conducted and does not object. But to rely on rulings of this nature when it is possible to obtain a consent in writing is to invite a lengthy trial over disputes of fact. There are other obvious advantages to the written consent form. It can be used as a vehicle, not only to obtain approval for the specific surgery contemplated but also to authorize discretionary modifications of the operation based on new knowledge or conditions arising after the patient is unconscious. Also, the consent form is a perfect vehicle in appropriate cases for establishing that the patient's judgment was informed, i.e., that he had been acquainted with the various risks and options involved. This evidentiary function is served by briefly detailing these factors on the form itself. The problem of assuring that consent is sufficiently informed, is the most difficult one in this area. It is not necessary to disclose minimal risks not normally mentioned by the profession such as the danger of contracting hepatitis from a blood transfusion. Indeed, the majority of states formulate the duty to disclose risks in terms of what doctors in the community customarily reveal. As medicine grows increasingly complex, this approach tends to conflict with the need to preserve meaning-

ful individual control over bodily invasions. Let me illustrate the difficulties by drawing on a recent case decided by a federal district court applying Alabama law. A housewife with a prior history of an overactive thyroid gland visits her doctor with a nodule in the neck and suffering from extreme nervousness. The doctor determines that the housewife's thyroid gland again requires treatment. The medical options at this point—as I understand them—could only be staggering to the layman. First the doctor must decide whether surgery, radio iodine, or antithyroid drugs are the appropriate treatment. Each option carries with it its own risks of failure and its own collateral hazards. If the doctor decided on surgery, he must then choose between two surgical techniques, one the standard and the other Lahey method, each of which present different approaches to avoidance of harm to recurrent laryngeal nerves, a major hazard of the thyroidectomy. The risk of damage to these nerves and consequent impairment of speaking ability is increased with a second operation. The problem is how much to tell the patient about these factors. In the Alabama case, the surgeon operated on the patient first in 1954 using the standard method to remove 95 per cent of the gland with apparent success. In 1959, symptoms reappeared. The defendant again decided on surgery, this time with the Lahey method. He told the patient little more than that the procedure would be similar to one she had undergone in 1954. Sometime after the 1959 operation, the housewife experienced hoarseness and unconsciously substituted the use of her false vocal chords. Experts diagnosed her problem as the failure of the recurrent laryngeal nerve to function properly. The housewife based her subsequent malpractice claim in part on the failure of the surgeon to sufficiently advise her of the seriousness of the operation. The district court rejected this argument stating:

> Doctors frequently tailor the extent of their pre-operative warnings to the particular patient, and with this I can find no fault. Not only is much of the risk of a technical nature beyond the patient's understanding, but the anxiety, apprehension and fear generated by a full disclosure may have a very detrimental effect on some patients.

In effect, this court claimed for the doctor a therapeutic privilege of withholding material risk data from the patient in order to protect her emotional health. Other courts have reached a similar conclusion in cases involving thyroidectomies. The commentators who write in legal journals have questioned whether this line of cases gives adequate protection to the inviolability of the person which ranks very high in the common law scheme of values. Quite apart from such theoretical concerns, a reluctance to use any therapeutic privilege unless the patient's welfare requires it would seem justified. The danger is that surgeons will generally dilute the content of their preoperative disclosures. Such a dilution will only increase the number of cases in which patients and families are shocked by unexpected, unfavorable results. Shock of this type is a primary cause of malpractice claims; which returns us to the trend toward proliferation of medical malpractice suits that we noted at the outset. As it becomes increasingly difficult to explain all the options and risks to the patient, I expect the number of malpractice claims alleging battery to increase. All of which lead me to a completely defensive suggestion: Make sure your malpractice insurance provides you with coverage against claims alleging battery as well as those framed in negligence. Some policies have not included both theories in the past, but protection against both would now seem to be essential for the prudent practitioners today. In summary, the law requires that your treatment come up to the customary standard of the profession and that you proceed with informed consent in your case. If you document your satisfaction of these requirements as you go along—the risk of malpractice suit is materially reduced.

Comments Of Birmingham Doctor In Medical Journal

Dr. John W. Kirklin, professor and chairman of the Department of Surgery, University of Alabama Medical Center, is one of five U. S. physicians whose comments on use of water and sodium in surgical procedures are included in a recent issue of *Modern Medicine*, a national medical journal.



Dr. Kirklin

The comments appear as a "Forum" feature.

Dr. Kirklin, who specializes in general surgery and cardiovascular disease, is a 1942 graduate of Harvard Medical School. He is a member of numerous medical organizations including the American College of Surgeons, American Surgical Association, Society of University Surgeons, American Association for Thoracic Surgery, and American Academy of Pediatrics.

Dr. Kirklin wrote: The question, "Are large amounts of water and sodium during and immediately after major surgery necessary?" is being asked by many surgeons and anesthesiologists. In spite of the inexactness of "large," the question can be discussed. It is a question primarily because of the tendency of some surgeons and anesthesiologists to give very large—5,000 ml. or more—amounts of a balanced salt solution to most of their patients during and early after operation. The tendency developed to some extent from misinterpretation of early work of Shires and perhaps because the phrase "Ringer's lactate" has such a physiological ring. One wonders if the trend would have been so popular if the phrase were "salt solution."

Some facts are available. At the Mayo Clinic in the early 1940s, most patients received less than about 500 ml. of fluid, plus whatever blood was required, during operation, and in the first twenty-four hours thereafter routinely were given 1,000 ml. of 5% glucose in water intravenously and 2,000 ml. of normal saline solution subcutaneously. Generally, they did well. For the last ten years on my own general surgical service and on my cardiovascular service, patients routinely have been given only about 1,250 ml. of 5% glucose in water and no sodium during the first twenty-four hours after operation. During operation, only small amounts of fluid are administered except under special circumstances. Generally, these patients have done well. With such a program, 500 to 1,200 ml. of urine are usually excreted during the first twenty-four postoperative hours. The compensatory mechanisms of most surgical patients are such that most do well under many different types of programs for fluid administration. When large amounts of essentially normal saline are given—2,000 ml. or more—during or early after operation, the volume of extra-cellular fluid is increased. If renal function is normal, the excess fluid is excreted during a diuretic phase existing about forty-eight hours after operation. If the diuresis does not occur, there is a tendency for the extracellular fluid to collect in the lung, especially in older patients or those with heart disease. Thus, a few patients may not do well with some programs of fluid replacement.

To these facts two platitudes may be added. If more water or sodium is needed by a postoperative patient, it can easily and quickly be administered. If too much water or sodium is inside of surgical patients, it is sometimes difficult to remove.

With these ideas in mind, we conclude that, with certain exceptions, patients should be given only small amounts—about 500 ml. —of 5% glucose in water during operation plus whatever blood is required. Postoperatively, while nothing is taken by mouth, 750 ml. of 5% glucose in water per square

meter of body surface area per twenty-four hours are given intravenously. This procedure provides some calories and water in an amount approximately equal to the sum of insensible water loss and obligatory water loss by the kidney, minus water released or produced by metabolic processes. No sodium need be administered during the first forty-eight hours after operation. These routines are, of course, altered under special circumstances. After the first forty-eight postoperative hours, 350 ml. of 5% glucose in normal saline solution per square meter of body surface area per twenty-four hours are added to the basic water intake. Potassium is usually added. If essentially nothing can be taken by mouth by the seventh postoperative day, special techniques for high caloric intravenous feeding are begun.

Obviously, we conclude that "large amounts" of water and sodium are not required routinely by surgical patients.

Who's Afraid Of Big Bad Wolf?

Questioning the validity of recent scientific data linking lung cancer to cigaret smoking, the tobacco industry is mounting a major attack against its biggest critic—the American Cancer Society.

The Tobacco Institute, the industry's trade association, announces an advertising campaign to challenge the Cancer Society to release still unpublished data on lung cancer in dogs for further scrutiny by "men of outstanding competence and integrity" and at the Tobacco Institute's expense.

The experiment that's upsetting tobacco men was reported Feb. 5 at a Cancer Society meeting. Two scientists, whose work was partly financed by the society, reported they had trained beagles to smoke through holes cut in their throats. Some of the dogs died from lung diseases, such as emphysema, and 12 others were found to have lung cancer, the scientists reported. The results of the experiment haven't yet been published in a scientific journal.—Wall Street Journal

Synthroid®
(sodium levothyroxine)

Indications: SYNTHROID (sodium levothyroxine) is specific repl ment therapy for diminished or absent thyroid function resu from primary or secondary atrophy of the gland, congenital de surgery, excessive radiation, or antithyroid drugs. Indications SYNTHROID (sodium levothyroxine) **Tablets** include myxede hypothyroidism without myxedema, hypothyroidism in pregna pediatric and geriatric hypothyroidism, hypopituitary hypothyr ism, simple (non-toxic) goiter, and reproductive disorders associa with hypothyroidism. SYNTHROID (sodium levothyroxine) **Injec** is indicated in myxedematous coma and other thyroid dysfunct where rapid replacement of the hormone is required. When a tient does not respond to oral therapy, SYNTHROID (sodium l thyroxine) injection may be administered intravenously to avoid question of poor absorption by either the oral or the intramusc route.

Precautions: As with other thyroid preparations, an overdos may cause diarrhea or cramps, nervousness, tremors, tachycar vomiting and continued weight loss. These effects may begin a four or five days or may not become apparent for one to three we Patients receiving the drug should be observed closely for sign thyrotoxicosis. If indications of overdosage appear, discont medication for 2-6 days, then resume at a lower dosage level patients with diabetes mellitus, careful observations should be m for changes in insulin or other antidiabetic drug dosage requ ments. If hypothyroidism is accompanied by adrenal insufficiency Addison's Disease (chronic subcortical insufficiency), Simmon Disease (panhypopituitarism) or Cushing's syndrome (hyperad alism), these dysfunctions must be corrected prior to and du SYNTHROID (sodium levothyroxine) administration. The d should be administered with caution to patients with cardiovasc disease; development of chest pains or other aggravations of diovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction.

Side effects: The effects of SYNTHROID (sodium levothyrox therapy are slow in being manifested. Side effects, when they occur, are secondary to increased rates of body metabolism: sw ing, heart palpitations with or without pain, leg cramps, and wei loss. Diarrhea, vomiting, and nervousness have also been observ Myxedematous patients with heart disease have died from abr increases in dosage of thyroid drugs. Careful observation of patient during the beginning of any thyroid therapy will alert physician to any untoward effects.

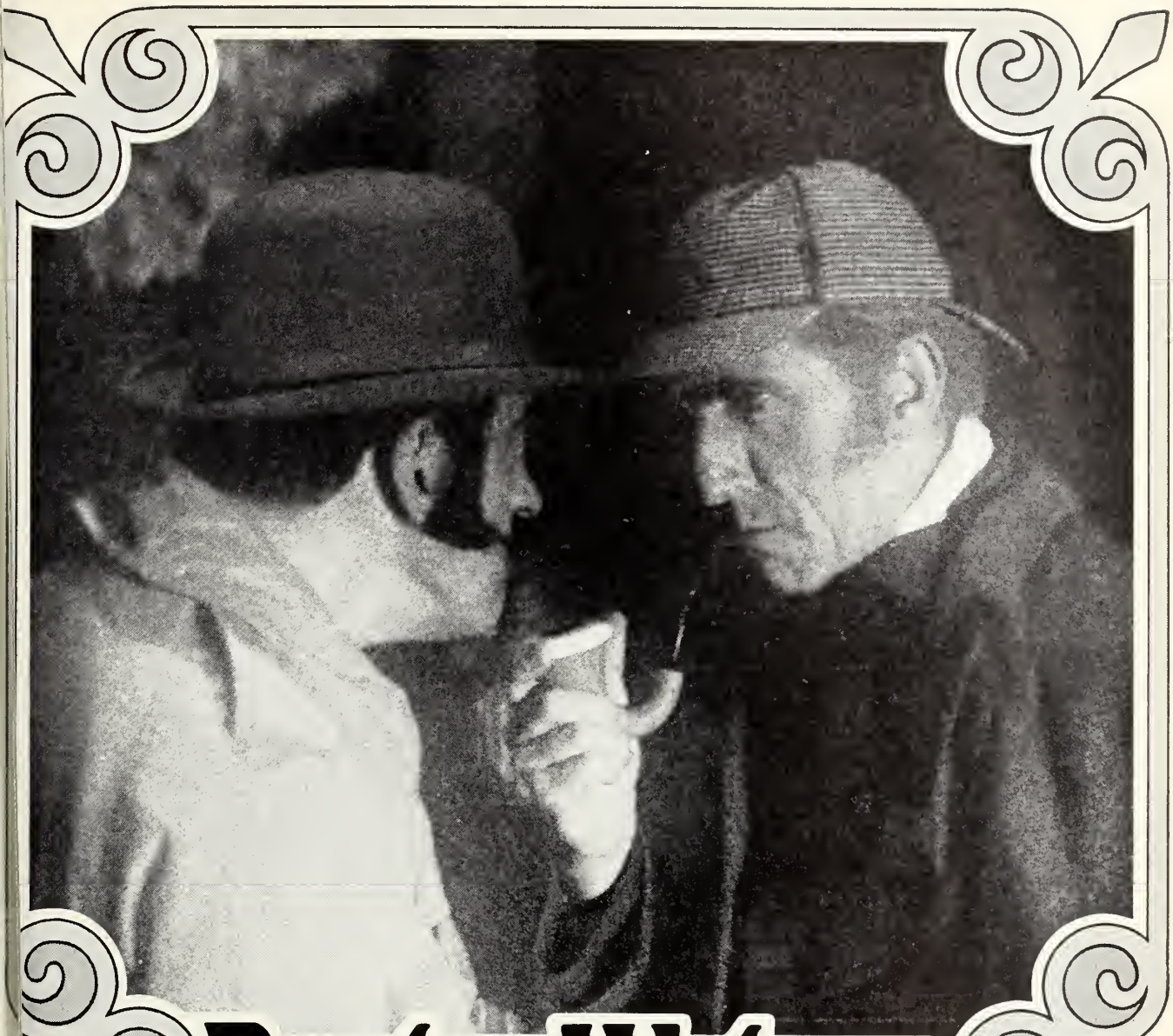
In most cases with side effects, a reduction in dosage followed a more gradual adjustment upward will result in a more accur indication of the patient's dosage requirements without the appe ance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHR (sodium levothyroxine) TABLET is equivalent to approximately grain thyroid, U.S.P. Administer SYNTHROID tablets as a sin daily dose, preferably after breakfast. In hypothyroidism with myxedema, the usual initial adult dose is 0.1 mg. daily, and may increased by 0.1 mg. every 30 days until proper metabolic balance attained. Clinical evaluation should be made monthly and measurements about every 90 days. Final maintenance dosage usually range from 0.2-0.4 mg. daily. In adult myxedema, start dose should be 0.025 mg. daily. The dose may be increased to 0 mg. after two weeks and to 0.1 mg. at the end of a second two wee The daily dose may be further increased at two-month intervals 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 m daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., mg., 0.5 mg., scored and color-coded, in bottles of 100 and 500. Inj tion: 500 mcg. lyophilized active ingredient and 10 mg. of Mann N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chlori Injection, U.S.P., as a diluent.

SYNTHROID (sodium levothyroxine) INJECTION may be admin tered intravenously utilizing 200-400 mcg. of a solution containi 100 mcg. per ml. If significant improvement is not shown the follo ing day, a repeat injection of 100-200 mcg. may be given.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC
Morton Grove, Illinois 60053



Doctor Watson exposes a double agent

Fo on the Embankment. Two figures emerge into silhouette against a ha ed street lamp. The flare of a match reveals the profile of Sherlock Hmes. As he lights his calabash, his companion speaks:

"I Jove, Holmes, that amazing intuition of yours has proved right ag n. What we're looking for is a single entity. I thought we were de ing with several others—even twins. But now—I'd say we've un overed a double agent."

"Tll me more, Watson, and be quick about it!"

(W tson withdraws a folded paper from inside his greatcoat, and re s aloud from it):

"Te key to the whole cypher is SYNTHROID (sodium levothyro ne)"...

"Shh! Watson, not so loud! You'll alert our quarry."

(Watson continues): "A single entity that serves two functions."

"A master stroke, Watson."

"F low along, Holmes. In the neighborhood of 95% of the circulating hyroid hormone is levothyroxine—T_4 as you call it. T_4 is bound to yroxine-binding proteins in the serum. It becomes available only gra ually to tissue cells—as free thyroxine."

"Is that why there's such a smooth, predictable response, Watson?"

"Quite! With agent T_4, SYNTHROID, the chances of a precipitous rise in metabolic rate are lessened."

"But how does 'free' thyroxine fit into the picture?"

"Well, Holmes, you might call it the tissue thyroid hormone—because 'free' thyroxine (that is, thyroxine not bound to protein) is active at the tissue level. It is gradually released from thyroxine-binding proteins. Each daily dose of SYNTHROID is mostly bound to thyroid-binding proteins, and slowly released as 'free' thyroxine—the form in which it is metabolically active."

"Magnificent, Watson! So protein-bound thyroxine is the major form of circulating thyroid hormone, and it is released as 'free' thyroxine. And that's why SYNTHROID is able to simulate the normal process so artfully. Q.E.D."

"Not so fast, Holmes. SYNTHROID works for the *physician*, too. Because its dosage is more precisely controllable, and because response is so smooth and predictable, the *doctor* gets fewer phone calls in the wee hours from agitated patients. Both parties get more sleep!"

"Comforting, my dear doctor, to know that SYNTHROID, the 'single agent,' cleverly does the job of two."

Synthroid® (sodium levothyroxine)

Now available for your prescribing needs



Cordran® Tape

Flurandrenolide Tape (4 mcg. per sq. cm.)

Additional information available upon request • Eli Lilly and Company, Indianapolis, Indiana 46206

000121

Lilly

THE JOURNAL
of
THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA
Published Under the Auspices of the Board of Censors

Volume 39 June, 1970 No. 12

A Proposal For The Management Of Hodgkin's Disease At The University Of Alabama Medical Center Birmingham, Alabama

Donn J. Brascho, M. D., John R. Durant, M. D.,
Frank G. Moody, M. D., Robert E. Roth, M. D.,
and William A. Maddox, M. D.

High cure rates are possible in the treatment of Hodgkin's disease with meticulous and aggressive radiotherapy. Statements found in some textbooks delegating a hopeless prognosis to patients with this disease are no longer correct. The systematic approach to the problems of this disease taken during the last decade by pathologists, hematologists, and diagnostic and therapeutic radiologists has yielded exciting new data about the natural history and treatment of Hodgkin's disease. It has now been shown that alteration in prognosis can be achieved by the application of modern techniques of extended-field, high-dose supravoltage radiation therapy.

Three major developments have lead to these more favorable results. First, the availability of supravoltage therapy units made it possible to treat larger volumes of tissue and still not exceed patient tolerance. Secondly, the development of lower extremity lymphangiography allowed early detection of disease in the retroperitoneal area. Statistics indicate that approximately 50 per cent of the patients have disease in this location which would not have been diagnosed without lymphangiography[1]. Involvement of this previously "blind" area was a frequent cause of failure in the management of Hodgkin's disease. Presence of disease here indicates a need for treatment, and appropriate therapy will significantly increase the chance for cure.

Lymphangiography has also allowed a better understanding of the natural progression of Hodgkin's disease. Information gained from lymphangiography strongly supports the hypothesis that this is a unicentric rather than multicentric disease. Observations also indicate that spread is predictable and by contiguous lymphatics in the great majority of cases. This knowledge has greatly influenced the radiotherapeutic management of these patients.

The third significant development was the reclassification of the histopathology of Hodgkin's disease. In 1963, Lukes[2] introduced a histological classification in which the relative number of lymphocytes and fre-

From the Departments of Radiation Therapy, Surgery, and Hematology and Oncology, The University of Alabama Medical Center, Birmingham, Alabama.

quency of Reed Sternberg cells present in the abnormal nodal tissue is significant (Figure 1). These factors have shown a definite correlation with clinical stage and prognosis. When lymphocytes predominate, there is a good prognosis; however, when there is depletion of lymphocytes, the prognosis is poor. This correlation has allowed a better understanding of the clinical course of a patient with Hodgkin's disease, and has become an important consideration in the management.

Histolcgic Classification of Hodgkin's Disease

Lymphocytic Predominance
(Nodular or Diffuse)
Nodular Sclerosis
Mixed Cellularity
Lymphocytic Depletion

Figure 1.

Historical Background

Just as there have been dramatic changes in our understanding and attitudes about Hodgkin's disease, there have also been great changes in therapeutic management. The fact that this malignant tissue is very radiosensitive has long been known by radiologists. Large lymph node masses shrink rapidly with low doses of radiation, and this lulled therapists into thinking that low-dose treatment to areas of known disease was sufficient, especially since the general philosophy regarding cure was one of pessimism and defeatism. This low-dose, limited-field policy was widely practiced prior to 1960; and the average five-year survival rate was approximately 30 per cent, with almost all patients dying in ten years. In 1958, Dr. M. Vera Peters[3], of Toronto, Canada, introduced the concept of treating adjoining, clinically uninvolved lymph node areas in addition to the region of known disease. This "prophylactic irradiation" was usually to low-dose levels, but did result in significant improvement in survival rates. Peters then noted that even better results were possible if higher doses were given to both the area of involvement and the contiguous regional lymphatics.

In 1962, Dr. Henry Kaplan initiated a clinical prospective study at Stanford University Medical Center to determine if radiation of adjoining node areas would improve results and if radiation of all nodal areas in generalized disease would influence survival rates or length of remission. He also wished to evaluate patient tolerance of extended-field, high-dose radiotherapy. After about three years it became apparent that the radical treatment was well tolerated, and short-term results suggested that permanent ablation of Hodgkin's disease was possible, even in advanced cases. The results were so impressive that randomization was discontinued and all subsequent patients were treated aggressively with high-dose, wide-field radiation therapy.[4]

Current Management

The clinical staging recommended by the International Committee on Staging of Hodgkin's Disease[5] in 1965 has been widely accepted (Figure 2). There is general agreement that Stage I or II Hodgkin's disease should be treated with radiation therapy. The work of Kaplan has influenced most radiation therapists to develop a policy of treating all lymphatics on one side of the diaphragm for Stage I or II disease. The principle of en bloc treatment in continuity is applied whenever possible. This entails large opposing radiation fields which encompass the entire neck, supraclavicular region, axillae, and mediastinum. The fields are meticulously shaped by the interposition of lead blocks between the radiation source and the patient to protect normal structures; in particular, the lungs, larynx and spinal cord. These large, shaped fields over the neck and trunk are called "mantle fields," and are utilized to treat Stage I and II Hodgkin's disease under the principle of delivering tumorcidal doses to the known disease and to all potentially involved adjoining areas (undetected disease).

International Staging for Hodgkin's Disease

Stage I Disease limited to one anatomic region (Stage I_1) or two contiguous anatomic regions (Stage I_2) on the same side of the diaphragm.

Stage II Disease in more than two contiguous anatomical regions or in two noncontiguous regions on the same side of the diaphragm.

Stage III Disease on both sides of the diaphragm, but not extending beyond the involvement of lymph nodes, spleen, or Waldeyer's ring.

Stage IV Involvement of the bone marrow, lung parenchyma, pleura, liver, bone, skin, kidneys, gastrointestinal tract, or any tissue or organ in addition to lymph nodes, spleen, or Waldeyer's ring.

All stages subclassified as "A" or "B" to indicate the absence or presence, respectively, of systemic symptoms (fever, night sweats, or generalized pruritis).

Figure 2

Optimal radiotherapy in Hodgkin's disease requires delivery of 4000 rads tissue dose in four weeks. Kaplan[6] has shown that the risk of recurrence in the field of treatment is inversely proportional to radiation dosage, and the recurrence rate is less than four per cent at a dose of 4000 rads given at the rate of 1000 rads per week. This amount has been accepted as the tumorcidal dose for Hodgkin's disease. To achieve this dose to large areas, such as a mantle field, megavoltage energy radiation beams are necessary. Sources of this radiation include linear accelerators, betatrons, and telecobalt-therapy machines.

Prior to Kaplan's clinical trial, Stage III patients were usually treated with low doses of radiation to limited areas or by chemotherapy, with a goal of palliation. However, his experience has substantiated that patients with Stage III Hodgkin's disease are able to sustain extended-field, high-dose irradiation to all regions of involvement with remarkable tolerance. Fifty per cent of such patients survived without evidence of disease for periods up to five years in Kaplan's series.[7] Treatment in this situation consists of radiation to mantle fields, as previously described, followed by irradiation of lymph node chains below the diaphragm, including the paraortic, iliac and inguinal nodes, and also the spleen.

In following Stage I and II cases treated with segmental irradiation technique (mantle fields), Kaplan observed that 36 per cent later developed disease below the diaphragm, even though they had negative lymphangiograms at the time of original staging. For this reason, he initiated a program of "total nodal irradiation" (T.N.I.) for all stages. In a series of 28 cases of Stage I and II disease, followed one to 7.5 years after total nodal irradiation, 26 (93 per cent) were alive without evidence of disease.[7] This is a further improvement over his reported 82 per cent five year survival with the extended segmental field technique. Johnson[8] reported similar results in a series of patients treated at the National Cancer Institute.

There has been a natural reluctance by radiotherapists to adopt a policy of total nodal irradiation for patients with early disease. A high percentage of these patients have no need for such aggressive therapy and risk serious complications by receiving it. These risks, or complications, include significant bone marrow suppression, gastrointestinal disability, possible renal and pulmonary dysfunction, and sterility and menopause in young females. Kaplan also recognized this problem, and the need for more accurate selection of patients for T.N.I. He therefore began a clinical trial in which 65 unselected cases were staged surgically by diagnostic laparotomy. At the time of surgery, abdominal lymph nodes were biopsied, wedge and needle liver biopsies were per-

formed, and the spleen removed. Approximately 30 per cent of patients who presented no clinical or radiographic evidence suggestive of subdiaphragmatic involvement had occult Hodgkin's disease in abdominal nodes and/or spleen. Nodes near the hilum of the spleen, which are not filled by lymphangiography, were involved in the majority of cases.[7]

There are many advantages of diagnostic laparotomy and splenectomy for staging patients with Hodgkin's disease. Currently available clinical methods of detecting abdominal disease have limitations. Since aggressive radiation therapy can control nodal disease and chemotherapy can give long-term control of extranodal disease, it is extremely important to accurately determine the extent of disease so that appropriate treatment can be given. Patients who have no disease below the diaphragm can be spared further treatment and the risks associated with total nodal irradiation therapy.

In patients who do have subdiaphragmatic disease and do require irradiation, there are definite advantages to splenectomy. With the spleen removed, the left upper quadrant of the abdomen may be excluded from the irradiation ports. This spares the left kidney and left lung base from possible radiation damage. Also, with the spleen removed, the patients have been observed to tolerate the treatment better, with less suppression of the peripheral blood count during radiotherapy[7].

Another advantage of laparotomy is that it permits oophoropexy to be performed in the young female who requires further irradiation. This consists of placement of both ovaries with their attached pedicles in the midline of the pelvis. The ovaries can then be shielded with lead blocks during irradiation without interfering with treatment of the external iliac, obturator, or hypogastric nodes. In the experience at Stanford, this procedure has resulted in continued menstruation of approximately 50 per cent of patients after completion of radiation therapy.[9]

Liver wedge biopsy at the time of laparotomy will most accurately diagnose liver involvement, which is very common in late Hodgkin's disease. In this situation, radiation therapy cannot control disease, and chemotherapy is indicated. In a series of cases with far advanced Hodgkin's disease treated at the National Cancer Institute with a multiple drug program, including Nitrogen Mustard, Procarbazine, Vincristine, and Prednisone, approximately 50 per cent of cases remained free of disease for a period of two years or longer.[10]

Kaplan is continuing this clinical trial of diagnostic laparotomies, and other respected investigators are now routinely exploring the abdomen in an attempt to improve the accuracy of staging. Members of the Oncology, Surgical and Radiation Therapy Departments of the University of Alabama Medical Center recognize the benefits of this policy, and propose that a similar policy be adopted for patients received for evaluation and treatment of Hodgkin's disease at the University Hospital and the Veterans Administration Hospital, Birmingham, Alabama.

Proposal for the Management of Hodgkin's Disease

I. Histological diagnosis should be confirmed on all patients with Hodgkin's disease, and classified under Luke's classifications as lymphocytic predominence, nodular sclerosing, mixed or lymphocytic depletion.

II. Work-up will include history, complete physical examination, chest X-ray, IVP, CBC and platelet count, alkaline phosphatase, bone survey (X-ray or radioisotope scan), urinalysis, lymphangiography, bone marrow biopsy, and piromen stimulation test.*

III. Should the bone marrow biopsy be negative and there be no clinical contraindication to abdominal exploration, the following procedure will be performed:

*The piromen stimulation test measures the response in the peripheral blood to an endotoxin. This is used as a measure of functional bone marrow reserve in an attempt to predict patient tolerance to chemotherapy or extended field radiation.

1. Laparotomy.
2. Abdominal lymph node biopsies.
3. Liver biopsies (both wedge and needle).
4. Splenectomy with surgical clip placed on splenic pedicle.
5. Oophoropexy in premenopausal women (surgical clips placed on ovaries).

IV. Following the above procedures, the patient will be staged, using the International Staging recommended at Rye, New York, 1965, including "A" to indicate absence and "B" the presence of systemic symptoms, which consist of fever, pruritis, and night sweats.

V. Management by stage:

Following the results of these studies, patients will be treated in the following fashion. Patients whose abdominal exploration is negative (Stage I or II) will have radiation therapy delivered only to the lymph node bearing areas above the diaphragm. An attempt will be made to deliver 4,000 rads in four weeks through one anterior and one posterior port with supravoltage equipment.

Patients who are found to have abdominal disease without liver involvement (Stage III) will be treated by the addition of abdominal and pelvic ports which will include the paraortic and iliofemoral node areas, and an attempt will be made to deliver 3,500 rads to 4,000 rads in four weeks. A suitable rest period will be given between segments to allow patient recovery and preserve tolerance.

Patients found to have liver or bone marrow involvement (Stage IV) will not receive radiation therapy, except as it is necessary for the rapid reduction of a large bulk of tumor causing symptoms or signs of obstruction. The primary modality for these individuals will be multiple drug chemotherapy as dictated by the judgment of the Division of Hematology and Oncology. A specific protocol for the management of these patients with chemotherapy cannot be given at this time because of the advent of a number of new effective agents for which combinations are being developed which may prove to be superior to the presently-employed regimen of the National Cancer Institute. All such treatment protocols will, however, be submitted as ancillary studies to the activities of the Southeastern Co-operative Cancer Chemotherapy Study Group of the National Cancer Institute before its use is approved in patients.

It is realized that some patients will not fit neatly into this plan of management. This is especially true in patients with Stage III disease who have systemic symptoms. Some of these patients are so ill that they will not tolerate total nodal irradiation and are not logical candidates for laparotomy. In this situation, particularly in the mixed or lymphocytic depletion histologic type, chemotherapy will be the preferred treatment, with irradiation to local areas utilized as supplemental therapy.

Results of treatment in patients staged clinically and those staged surgically will be compared to determine the relative advantages of one method over the other. Also, complications of treatment will be recorded in both groups and compared. Analysis will be made of patients given total nodal and splenic irradiation and compared with those having splenectomy and irradiation. A worksheet will be developed for collecting clinical information and the results tabulated. Such information will be stored in the Tumor Registry computer system for ready retrieval of data. The results will be compared for the groups, and the feasibility and advisability of laparotomy determined. Should the survival results be the same in those receiving total nodal irradiation and those having surgical staging, the more limited use of radiation and the appropriate administration of chemotherapy in the latter will be sufficient reason to justify the continued use of diagnostic laparotomy.

Summary

Application of modern techniques of extended-field, high-dose supravoltage radiotherapy has resulted in survival rates of 80 to 90 per cent in early stages of Hodgkin's disease. Irradiation to inadequate fields or inadequate amounts can jeopardize the chance for cure, and therefore is not justified. However, it is difficult to justify irradiation of large volumes of normal tissues in patients who may not need this extensive therapy. Since detection of intra-abdominal disease by clinical methods has limitations, diagnostic laparotomy is a logical step in the management of the patient with Hodgkin's disease.

Bibliography

1. Davidson, J. W., and Clarke, E. A.: Influence of Modern Radiological Techniques On Clinical Staging of Malignant Lymphomas. Canad. Med. Ass. J. 99:1196-1204, 1968.

2. Lukes, R. J.: Relationship of Histologic Features to Clinical States in Hodgkin's Disease. Amer. J. Roentgen. 90:944-955, 1963.

3. Peters, M. V., and Middlemiss, K. C. H.: A Study of Hodgkin's Disease Treated by Irradiation. Amer. J. Roentgen., 79:114-121, 1958.

4. Kaplan, H. S., and Rosenberg, S. A.: Extended-field Radical Radiotherapy in Advanced Hodgkin's Disease: Short-term Results of Two Randomized Clinical Trials. Cancer Res., 26-1268-1276, 1966.

5. Rosenberg, S. A.: Report of the Committee on The Staging of Hodgkin's Disease. Cancer Res., 26:1310, 1966.

6. Kaplan, H. S.: Evidence for a Tumorcidal Dose Level in the Radiotherapy of Hodgkin's Disease, Cancer Res. 26:1221-1224, 1966.

7. Kaplan, H. S.: In Press. Presented at the Annual Meeting of the Radiological Society of North America, Dec., 1969.

8. Johnson, R. E.: In Press. Presented at the Annual Meeting of the Radiological Society of North America, Dec., 1969.

9. Ray, G. R., Trueblood, W., Enright, L., and Kaplan, H.: Oophoropexy, A Means of Preserving Ovarian Function Following Pelvic Megavoltage Radiotherapy For Hodgkin's Disease. In Press. Presented at the Annual Meeting of the Radiological Society of North America, Dec., 1969.

10. DeVita, V. T., Serpick, A., and Carbone, T. P.: Combination Chemotherapy of Advanced Hodgkin's Disease, The N. C. I. Program, A Progress Report. Presented at the American Association for Cancer Research, March 23, 1969, San Francisco, California.

Pulmonary Function Testing For The General Hospital And Physician

D. S. Tysinger, Jr., M. D.

Dothan, Alabama

PART VI—TOTAL LUNG VOLUME AND INTERPULMONARY MIXING

Vital capacity, maximum voluntary ventilation, tidal volume—and their ramifications—have been discussed thusfar. The next measurement, that of total lung volume, presents a much more difficult problem since it is impossible to actually measure total lung volume. The vital capacity can be accurately measured. If the residual volume can be accurately measured then by adding the vital capacity and the residual volume, the total lung volume can be obtained. The measurement that is made is that of functional residual capacity and it can be done in several different ways. By measuring a functional residual capacity (that volume of air remaining in the lung at the end of normal expiration) one can either then measure the forced expiratory reserve volume and subtract this from the functional residual capacity and obtain a residual volume, or by adding inspiratory capacity to the functional residual volume, the total lung volume can be measured. The measurement of the total lung volume must be done by this indirect method. Functional residual capacity can be measured using hydrogen or helium as a test gas. The closed circuit method uses, at present, primarily helium. The open circuit uses oxygen and nitrogen. The third way of measuring total lung volume is that of the body platysmograph. The expense of this instrument really negates its use in the average general hospital. This method will not, therefore, be discussed.

Diagram No. 9 from Article III is herein reproduced for reference.

First to be discussed will be the closed circuit method of measuring functional residual capacity. When this method was first devised the technique was not a difficult one. A spirometer with dead space reduced to as small a volume as possible was used. To this was added a known amount of helium and sufficient oxygen to breathe for about seven minutes. Before the oxygen was added, but after the helium was added, a line was made which gave the volume of helium plus the dead space of the spirometer, this gas mixed and helium concentrations recorded. After the oxygen was added sufficient to breathe for about seven minutes, time for mixing was allowed. At this point the patient was started breathing into the spirometer. Helium readings were taken frequently. As the patient breathed, the baseline slowly raised toward the previously written helium line. While the patient was breathing he did first an expiratory reserve volume and then an inspiratory capacity. He then continued to rebreathe until he breathed back up to the helium line. At this point the patient was disconnected from the machine. Knowing the original helium volume and concentration and the new diluted concentration of helium one could compute the total volume of the machine plus the patient's functional residual capacity and thus obtain functional residual capacity. It was very important in starting the procedure to watch the patient's breathing closely and, at such point as the patient had finished breathing out (end of expiration) he should be connected into the spirometer so that he started breathing in with only the volume of the machine dead space and functional residual capacity. If the patient was connected, or "cut-in," before he

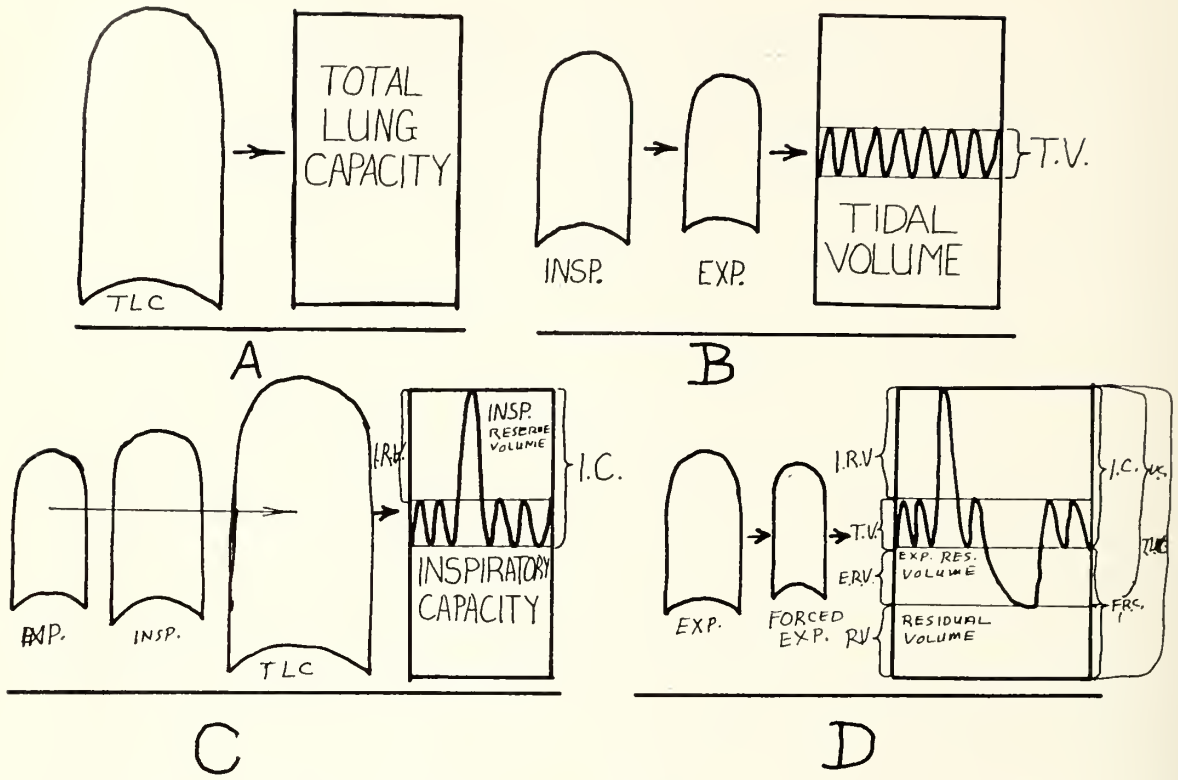


Diagram No. 9

reached full expiration then, after he is "cut-in" the marker would write down below the "cut-in" line and this would make the machine volumes and functional residual capacity volume increased by this amount. This amount had to be subtracted from the volume since it was part of the inspiratory capacity and would increase the volume of the functional residual capacity if not subtracted. If the patient actually went too far in blowing out to be "cut-in" when he returned to the baseline then the functional residual capacity would be too small and this amount must be added. It was noted that as the patient started to breathe the helium concentration would fall to a point while there was still oxygen in the system, but at which point, as he breathed and used up oxygen, the concentration would again go up. It was found that this helium low point and the time taken to reach it were definitely related to the fast and slow mixing components within the lung and had to do with interpulmonary mixing. This method for doing functional residual capacity is still a good one. Some individuals do not completely equilibrate, however, in this seven minute period of time. Therefore, a second closed circuit technique was devised in which the dead space of the machine is known, helium is added in a known amount and then a known amount of air is also added sufficient to allow an individual to do an inspiratory capacity. At this point the patient is "cut-in" and oxygen is added at the rate it is utilized by the body, thus producing a flat baseline. It is noted with this type of helium testing that the helium concentration will fall, rapidly at first and then more slowly toward the end (this again depending on interpulmonary mixing) and the end point will be taken as that point at which successive readings of the meter every 30 seconds remain the same (meaning that the volumes have equilibrated). At this point expiratory reserve volume and inspiratory capacity are again done and are used to determine residual volume and total lung volume.

Next, is the open-circuit technique for doing functional residual capacities. With this technique pure oxygen is breathed for seven minutes. The gas that is exhaled is collected and its total volume and nitrogen content are measured. In air, the normal nitrogen content is 79 per cent; however, as air enters the lungs and exchanges occur, more oxygen is taken out than carbon dioxide is put back in. For example, 250 cc. of oxygen are utilized by the body and 200 cc. of carbon dioxide are expelled by the body. This leaves a 50 cc. deficit which raises the nitrogen content in the lungs to 81 per cent. Therefore, by measuring the amount of nitrogen that is expelled and with an alveolar sample to measure the amount of nitrogen remaining, functional residual capacity can be determined. The basic premise is that of (1) cutting the patient into the system at complete expiration (2) of no nitrogen being excreted from the tissues (nitrogen is in equilibrium in the blood stream with the alveolar gases so that there is some nitrogen excretion) and (3) of all nitrogen contained within the lungs being washed out completely, which is also not the case. The functional residual capacity is equal to the nitrogen washed out of the lungs divided by 81. In actuality a more complicated formula must be used because of the preceding and because tank oxygen usually contains 0.2-1.0 per cent nitrogen. (This must be determined for every tank that is used for this type of procedure.) The gas volume collected must be measured in a Tissot spirometer and corrected for temperature and barometric pressure. Since all of the nitrogen cannot be washed out one must analyze for alveolar nitrogen, also. These are the common methods of measuring the functional residual capacity from which the total lung volume can be determined.

For a discussion of what can be derived from studying the functional residual capacity, the residual volume and the total lung volume, one may start with the restrictive diseases. In restrictive disease, as a total lung volume is done, the restriction interferes with the ability of the lung to move and, if this restriction does no reduce volume per se, then the ability to collapse the chest cage and the lung to the normal degree will not be present and some increase will be found in the residual volume and possibly in the functional residual volume. If the primary loss is of a space occupying nature, such as block pulmonary fibrosis, the functional residual capacity and residual volume are smaller than predicted, either of which will fit with restrictive disease. The total lung volume, as a rule in restrictive disease, is reduced because of the inability of the chest cage to expand fully as in the normal.

In obstructive disease the problem is a little different. Obstructive components are along the tracheobronchial tree, either as secretions, edema, proliferation of cellular elements, vascular engorgement, bronchospasm, etc. All of these tend to decrease the elasticity of the portion of the tracheobronchial tree involved. Along with this decrease in elasticity, there is also an increased resistance to air flow so that in normal breathing, in order to exchange air, the tidal volume is moved up the inspiratory portion of the vital capacity curve with an increase in functional residual capacity and ventilation may be maintained with the same degree of effort, due to larger tube diameter and less resistance. A comment should be made at this point about resting chest cage position. True resting chest cage position exists rarely, but is primarily based on the resistance to collapse by Force A (the diaphragm and chest cage) being equal to the elastic collapsing force of the alveoli and tracheobronchial tree (Forces B and C) so that the A forces are equal to B plus C forces. At the resting position there is no air flow so there would be no D Force. The restriction and obstruction must be subtracted from the C Force, and shifts the equation toward the A Force and makes the resting chest cage level assume a larger functional residual volume than would exist in the normal state. This is due to the decrease in the C Force. The degree of increase in the functional residual

capacity would therefore depend on the degree of involvement. As this increase occurs, the individual breathing with this larger functional residual capacity (with which he has to mix the inspired air in order to maintain alveolar exchange) must now breathe a larger volume, or hyperventilate, in order to deliver sufficient volume to maintain CO2 washout and maintain oxygen saturations at the alveolar level. At these greater volumes the only noticeable changes would be those of the hyperventilation plus the increase in oxygen consumption and CO2 production to produce this increase in work effort of breathing. This individual with the increased stiffness secondary to the loss of C Factor elasticity on forced expiration cannot reduce his lung volume as much as if the tracheobronchial tree was normal. Therefore, he now has an increased volume in the lungs when he has blown out all he can; thus, the residual volume is also increased secondary to the obstructive processes. As these diseases begin to develop, total lung volume may be within the normal limits so that in early obstructive disease there may be seen a normal total lung volume with an increased residual volume and functional residual capacity. As obstruction increases the lungs begin to hyperinflate and there is an increase in total lung volume. Thus, there is usually seen in moderate disease an increase in total lung volume in relation to predicted volume and an increase in residual volume in relation to predicted volume, but they both may be equal so that the residual volume to total lung volume comparison may still be fairly normal and vital capacity maintained normal. It can be seen that they are not normal because they are both increased. As the process becomes more severe there is a greater increase in the residual volume than in the total lung volume both of which may be massive and vital capacity volumes begin to decline. One of the basic evaluations is that of residual volume to total lung volume. Thus, it can also be seen that this ratio of residual volume to total lung volume, if it is 50-55 per cent, would be more significant if the total lung volume were 200 per cent of predicted volume than it would be if the total lung volume were 125 per cent of predicted volume. In evaluating the degree of severity these variations must be taken into account.

When trapping is present, it is usually typified by the obstructive pattern and causes it to be more severe. In the case of some large cyst that may be present, one might find three different patterns. If the cyst communicates fully, then there will be an increase in total lung volume, the cyst being ventilated and helium mixing occurring as otherwise. If the cyst has a small opening and is of large volume then it will equalize more slowly due to poor ventilation and may cause a marked increase in time necessary to reach equilibrium in doing the lung volume. Thus, a prolonged time factor itself suggests cystic areas with poor communications. When there is a large cyst that does not communicate with the tracheobronchial tree, then the actual total lung volume will be smaller and the cyst not equalized with helium as if it were a mass occupying the same space. In this instance, though chest X-ray and other signs would suggest a marked increase in lung volume, the helium lung volume would show a smaller lung volume than actually exists.

In the case of loss of pulmonary elasticity, such as emphysema, the situation is somewhat different. In this situation there is marked loss of tissue, particularly the small bronchiolar structures and alveoli in the process of alveolar ectasia producing the emphysematous cystic areas. As this occurs (1) the lung tissue itself is decreased in volume and (2) more important, the normal elastic alveolar structures with surfactant, etc., are lost. In this type of disease the first abnormality is a marked reduction in the B factor forces due to this loss of alveolar area and elasticity. As a result of this loss, the chest cage and diaphragm (Force A) must now expand the lungs by forceable work with little or no resistance, particularly from

Force B, and at the end of a normal inspiration Force A factors must also actively push the air back out of the alveolar area. Not only do these large air sacs not have an elastic force and do not enter into normal function, but they also tend to neutralize the normal and functioning alveoli by expanding easily as a normal alveoli collapse, thus requiring the chest cage (Force A factors) to be more active on inspiration and expiration. Therefore, the residual volume and functional residual capacity are both increased in relation to normal due to the B factor damage. As a rule, in the emphysematous individual there is a cause and this cause is usually obstructive pulmonary disease which does not diminish as the disease gets worse and as emphysema develops; therefore, there is also a reduction in C Factor forces so that as a result of the B and C Factor loss of elasticity and the increase in B area, due to tissue loss, there is a marked increase in the residual volume and functional residual capacity. There is also usually limitation of movement of the chest cage and diaphragm. As these conditions continue there is also the continuing difficulty with obstructive disease and trapping. With this type of situation, the chest cage must develop a rather high interstitial pressure in the lungs to cause collapse of cystic areas with pressure around the airways. This produces obstruction along the airways past obstructive elements which produces retardation of flow and a drop of interluminal pressure in relation to interstitial pressure. Thus, with this type situation there is a large residual volume, a large functional residual capacity due to loss of tissue and hyperinflation with marked increase in total lung volumes and rater marked increases in the residual to total lung volume measurement.

The next group of diseases to be discussed are those of the stiff lung: (1) heart failure, (2) increased surface tension states, and (3) the fibrotic lung.

In evaluating the residual volume and functional residual capacity and total lung volume in heart failure, the restrictive and stiff elements in this instance are due to pulmonary engorgement due to increased left ventricular endiastolic pressures and high pulmonary venous pressures with sequestration of fluid in the pulmonary circuit and with increased volume of fluid due to the right heart output being better than the left heart output. As this condition gets more severe than there is the interstitial collection of fluid, or interstitial edema, with further increase in stiffness and loss of elasticity and, finally, frank alveolar and bronchial fluid or ordinary pulmonary edema, subacute or acute. Due to the stiffness and engorgement of the lungs, the lungs cannot be collapsed as much as they can be in the normal; therefore, there is an increased residual volume. However, much of this stiffness and failure of collapse is due to increased fluid and blood sequestration in the lungs. Therefore, the increase is not as much as would be suspected. Likewise, the functional residual capacity is also increased slightly due to the same processes. The total lung volume is reduced in proportion to the increase in sequestered blood, interstitial fluid, and frank alveolar and bronchiolar edema fluid.

The second pattern is that of the stiff lung due to increased surface tension. In this situation there is usually associated pulmonary disease so that with total lung volume measurements there is found an increase in the residual volume and an increase in the functional residual capacity. In these instances there is usually an increase in the total lung volume so that this particular is different from that of heart failure.

In the third, or fibrotic lung, there may be found either an increased or decreased total lung volume depending on the type and amount of fibrosis, whether it be bronchial, peribronchial, generalized parenchymal, alveolar, pleural, etc. There may also be found the functional residual volume increased or decreased depending on the type of fibrosis which depends on the agent causing it and

the degree and extent of restriction produced by it.

The main differentiating factor in this group of stiff lungs is that of improvement by treatment of the first two, and the lack of improvement by treatment of the third.

One situation that has been unrecognized until recently is that of early terminal airway obstruction. This is seen most often in young individuals and is primarily an obstructive process involving the terminal bronchioles and respiratory bronchioles, those about one mm. in size. The patient usually complains of dyspnea but the X-ray is normal and, as a rule, so is the EKG, the vital capacity, and the maximum voluntary ventilation. These individuals, upon testing, are found to have an increased total lung volume with a moderate increase in the functional residual capacity and residual volume. They do get quite dyspneic and in the few seen by the author, diagnosis was made of psychoneurosis with hyperventilation when they were referred. However, upon testing, pH and PCO2 were normal and hyperventilation did not reproduce the symptomatology that the patients experienced. These conditions do improve with chronic bronchial dilator therapy and do show, on repeat total lung volumes, a drop in total lung volume and return a toward, or to, normal of the functional residual capacities and the residual volume. This is thought to be a massive and diffuse process, apparently nonspecific.

Interpulmonary mixing, or pulmonary mixing index, is determined by several different methods. The oldest and most established method is that of seven minute nitrogen washout. This has been supplemented and can be done rapidly with the single breath nitrogen washout method. During evaluation of tracings done by the early method of closed circuit helium lung volume testing, it was found that evaluation of a fast and slow mixing component could be derived from the helium concentration as it fell to its low point and then raised back to that of the equilibration at the end of using up the oxygen and coming back to the helium line. Later, with the new technique of breathing with a flat baseline and doing closed circuit helium lung volumes, it has been much simpler to determine 90 per cent mixing ideally and then evaluate what the individual does in relation to this 90 per cent mixing at the time that 90 per cent ideal mixing should have occurred. A technique that the author reported in 1965, "Hyperventilation Tests for Interpulmonary Mixing," was done using a stop watch and having the patient hyperventilate maximally to an end point. Also, in studying expired CO2 curves, it has been noted that the end tidal and end expiratory CO2 concentrations are also an indication of interpulmonary mixing. All of these various methods may be done and do give an indication of interpulmonary mixing efficiency.

What is the significance of interpulmonary mixing? Interpulmonary mixing is a somewhat ambiguous measurement, but on the other hand is an extremely didactic measurement. Interpulmonary mixing is not equal even in the normal lung. This was pointed out in Part One, "Normal Physiology," and Part Two, "Abnormal Physiology." Normal values have been derived for these differences in interpulmonary mixing or ventilation over the years so that there is a normal value with which to compare abnormality. As areas become emphysematous with loss of elasticity and flap to and fro with inspiration and expiration as a flag in the wind, then these areas are ventilated but they contribute little or nothing to gas exchange. They are part of the functional or physiological dead space and they cause inequalities in interpulmonary mixing. Likewise, areas beyond obstructions where gas mixing must be by diffusion rather than by flow, mix slowly because diffusion does not work as fast as ventilation. Those areas that demand diffusion filling and exit, cause poorer interpulmonary mixing. As there are varying degrees of these throughout the lungs, then there are varying degrees of interpulmonary

mixing abnormality. Poor interpulmonary mixing makes breathing inefficient and causes increased work to be done to maintain O2 uptake and CO2 washout.

The oldest of these is the pulmonary mixing index or the seven minute nitrogen washout. In this situation, the individual breathes pure oxygen for seven minutes as in doing the open circuit nitrogen washout functional residual capacity. At the end of this seven minutes an alveolar sample (that is, a sample of gas collected after normal expiration has occurred) from the functional residual capacity is analyzed for nitrogen. Normally this will be 1.5 per cent or less of the nitrogen remaining. As any lung disease causes poor interpulmonary mixing, this per cent increases. In emphysema, moderately severe or severe, this goes up to 8-10 per cent. With big cystic areas where mixing is slow, this may get as high as 25 per cent. Likewise, with the single breath nitrogen washout, a deep breath is taken of oxygen. This is breathed out to a point, at which point a sample is collected and analyzed for nitrogen. Here again the normal is 1.5 per cent. As difficulties arise, then these values are elevated.

Third is the 90 per cent helium mixing efficiency. In these situations the ideal mixing is figured on the basis of functional residual capacity, machine dead space, starting volume, tidal volume, and respiratory rate. Knowing this ideal 90 per cent mixing, complete mixing can be easily calculated. Then, if the mixing at this point for the patient is calculated, one can figure the per cent of actual mixing in the patient to the ideal 90 per cent mixing. Usually if mixing is 76 per cent or better of predicted 90 per cent mixing efficiency, then the interpulmonary mixing is normal. As the 90 per cent mixing efficiency for helium drops below 76 per cent, interpulmonary mixing gets worse. This might get quite low in cysts and bulli. Helium 90 per cent mixing efficiency is equally as valid as is the seven minute nitrogen washout.

The fourth method that was mentioned, hyperventilation, is a test that was devised based on the ability of the individual to breathe as deep and fast as he could "hyperventilate." The normal individual sitting up and hyperventilating at maximum can reduce his CO2 to about 10 mmHg. and increase his pH to around 7.45-7.5, at which point there develop symptoms of lightheadedness, perioral numbness, numbness and tingling of the extremities, and all of the symptoms of hyperventilation. Using this as an end point with a watch with a sweep second hand to keep track of time in seconds, then the normal sitting individual can in 25-35 seconds, hyperventilate to the point that he produces these symptoms (which means he is able to wash the carbon dioxide out) and this is a normal hyperventilation time. As interpulmonary mixing becomes defective then this ability is slowed and it takes longer for the individual to ventilate off enough CO2 to produce these symptoms of hyperventilation. This test has one advantage. If the individual is hyperventilating to begin with, then he is starting at a lower PCO2 and elevated pH to begin with and usually within ten to fifteen seconds this end point is noted. This is common particularly in individuals with heart failure. Normals tend to be prolonged, about 15 seconds, if the individual is supine. The beginning level of pH and PCO2 are the important factors. If the patient has high PCO2 and low pH as in respiratory acidosis, then it will take longer to produce the respiratory alkalosis. Also with high PCO2 and normal pH (compensated respiratory acidosis) PCO2 can be washed out. The rate at which it occurs is slower but still can occur. Only when disease gets severe does the situation arrive at which a patient cannot hyperventilate. From this a more scientific test of pulmonary efficiency has been developed, that of the 15 second carbon dioxide washout. The normal individual is able to ventilate off at least 15 mm. of mercury PCO2 in 15 seconds. This period will usually not cause symptoms. As less than 15 mmHg. is ventilated off in

this 15 second hyperventilation time, then there is a direct relation between the reduction in the pulmonary insufficiency of the patient and his ability to work.

Finally, the other test of interpulmonary mixing which seems to be valid is that of measuring end tidal versus end expiratory PCO2. In the normal individual, since end tidal air is alveolar in nature and interpulmonary mixing is normal, the end tidal and end expiratory PCO2 will be found to be the same. As interpulmonary mixing difficulties develop, then one begins to see the end expiratory PCO2 become elevated above the end tidal volume. The more it is elevated above the end tidal the greater the interpulmonary mixing difficulty.

The importance of interpulmonary mixing should be obvious. It is not only important in normal breathing that air get in and out of the lungs satisfactorily with little effort, that it mix with a not very great increase in residual volume or functional residual capacity so that hyperventilation is not required, but it is also important that air be distributed throughout the lungs in a normal fashion so that each area may get sufficient oxygenation and CO2 egress to maintain breathing. Diffusion difficulties, as will be discussed in the next issue on blood gases, may be simulated by either large residual volumes with which inspired air must be mixed or by poor interpulmonary mixing which essentially reduces the air ventilation to blood perfusion surface area so that the exact cause of diffusion difficulties may not be obvious in the beginning.

It should be obvious at this point that it is important to try to keep lung volume near normal, functional residual capacity and residual volume near normal, and interpulmonary mixing up to normal in order to maintain ventilation in and out of the lungs with the least effort.

Books Of Interest To Doctors And Patients

THE SEARCH FOR AIR SAFETY, by Stephen Barlay, William Morrow and Company, 105 Madison Avenue, New York City 10016, 410 pages including photoggraphs—$7.95.

Commercial aviation continues to build an impressive reputation for safe flying despite newspaper headlines of hijackings and accidents. And on the heels of every accident that happens is an investigating team on both sides of the Atlantic, intent on establishing the reason for what happened.

This is a completely fascinating book about these accidents, the teams that investigate them, how their findings have affected the course of aviation safety, told in an easy-to-read book that will prove reassuring and informative rather than frightening.

Here are the case histories of 107 aircraft accidents, all over the world, of the months of investigation that followed, of the causes of them, and of how this information from each was converted to greater safety in the millions of miles flown commercially every year.

It is in a way a "detective" story, and was first published in England under the title, *Aircrash Detective.*

—W. J. M., Jr.

Heart-Surgery Fiction

HEARTSBLOOD, a novel by Paul Marttin, M. D., Delacorte Press, 312 pages—$5.95.

Particularly in view of the illustrated lecture of Denton A. Cooley, M.D., before the scientific session of the Medical Association's annual meeting last month, the families of Alabama doctors will find this fictionalized story of heart surgery fascinating.

A native of Germany, the author grew up in Ohio, graduated from an Eastern college with his M.D., and is currently a professor of medicine. More than that, he writes well.

—W. J. M., Jr.



PROTEIN CONTENT / 7 oz. Serving*

Bean with Bacon	6.8	Green Pea with Ham (Frozen)	7.6
Beef	8.0	Hot Dog Bean	8.4
Chicken Broth	5.5	Pepper Pot	6.1
Chicken 'N Dumplings	5.8	Split Pea with Ham	10.2
Chili Beef	6.2	Vegetable Beef	5.0
Green Pea	6.9	Vegetable with Beef (Frozen)	5.4

When protein is the focal point in your patients' special diets, Campbell's Soups can be a convenient supplementary source of that essential nutrient.

* From "Nutritive Composition of Campbell's Products" which gives values of important nutritive constituents of all Campbell's Products. For your copy, write to Campbell Soup Company, Dept. 365, Camden, New Jersey 08101.



There's a soup for almost every patient and diet ...for every meal and, it's made by Campbell

You Can't Blame a Girl...



(when her husband's at fault)

Flagyl® brand of metronidazole

Cures Trichomoniasis in Both Women and Men

About half of all husbands of infected women harbor *Trichomonas vaginalis.**

Few of these men have symptoms. Even so, all are capable of perpetuating the infection and rendering treatment of a woman alone futile.

Only a systemically active medication like Flagyl is capable of reaching the hidden reservoirs of infection in the genitourinary tracts of both men and women.

Only Flagyl has been able to achieve rates of cure consistently above 90 per cent and often up to 100 per cent in trichomonal infections in both men and women.

Indications: For the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture.

Contraindications: Evidence of or a history of blood dyscrasia, active organic disease of the central nervous system and the first trimester of pregnancy.

Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia,* exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

Dosage Forms: Oral tablets . . . 250 mg.
Vaginal inserts . . 500 mg.

*References available on request.

SEARLE P. O. Box 5110 Chicago, Illinois 60680 942

Research in the Service of Medicine



Owner Breaks Arm When Yacht Runs Aground

Schuyler, Oct. 31. Harry Waters of Covesville incurred a fractured arm [illegible] large rock tially capsized. The fire departm had to rescue Waters by small b Damage to the yacht is estimate

Hasn't the skipper had enough excitement for one day?

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

A.H. Robins Company, Richmond, Va. 23220 A·H·ROBINS

Phenaphen® with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.





Peer Review And Medicaid

By Paul I. Robinson, M. D., Chief
Professional Division
Medical Services Administration

Medical Review Committees are relatively new in Health Insurance Administration. While Blue Cross and Blue Shield have had committees of physicians who have given advice to them for all the years of their existence, the advent of Major Medical Health Insurance, with its payment of reasonable and customary physicians' fees over and above fixed schedules, brought about a situation which needed the advice of a reputable segment of the profession. Much of the early work on Professional Review Committees was done in Pittsburgh, Pa. Originally the problems referred involved fees charged but as time went on problems involving necessity for medical care, hospital bed utilization and quality of medical care arose and had to be faced. Formidable as this sounds, the load on any one Medical Review Committee has not been overwhelming.

In so far as Government programs are concerned, the Dependent's Medical Care Program (now CHAMPUS) which began in 1956 required contractural arrangements between state medical societies and the Government for committees to which problems could be referred. Subsequent programs including Medicaid have had need for professional advice. The profession as represented by our national, state and local associations all advocate that Peer Committees be utilized in making difficult professional decisions as to fees, utilization of medical care facilities and service, quality and quantity of service and necessity for medical care. In earlier days, some physicians resented the Review Committees and sincerely felt that the members thereon were not superior to those whose work they reviewed. Undoubtedly, this is the reason for the use of the word PEER, since it connotates contemporary equality and study by fellow professionals.

Problems submitted to review committees can arise from the benefits administrators or paying agencies, the providers, and from the patients or their families. The great

This paper was presented at the Orientation Meeting of members of the Peer Review Committees of the Medical Association of the State of Alabama at the Admiral Semmes Hotel, Mobile, Alabama on May 2, 1970.

majority of the problems will come from the paying agencies who will detect in their normal operations unusual findings in cost, frequency of service, volume or length of service. We hope the mechanism for review for Medicaid will be something like this:

1. The fiscal agency for those cases arising therein will contact the provider, outline the problem, attempt to arrive at a mutual solution, but if this cannot be done, the facts will be submitted to the Medical Services Administration.
2. The Medical Services Administration will study the problem from a professional standpoint, and may contact the provider for further information. At this point the Medical Services Administration may decide that the problem is one for appropriate review by the Peer Committee. A physician will always be given a chance to discuss the problem with a staff M. D.
3. The Medical Services Administration will assemble the facts, contact the Peer Review Committee chairman and arrange for the Review Committee to consider the problem at a mutually agreeable time and place.
4. Some committees in other states have outlined procedures for submission of the cases to assure that facts are submitted. Initially, it is probably wise for the Chairman of the concerned committee to work out with the Medical Services Administration the method of approach for each case.
5. If professional specialty consultation is needed, the Medical Services Administration will pay for this service.
6. Peer Review Committees will make their recommendations in writing to the Director of the Medical Services Administration.
7. It has been traditional that the opinions of the Review Committees are accepted as final unless additional information not available to it becomes available, in which case the Committee is again consulted.
8. The Medical Services Administration will maintain a file of all Peer Committee reports and will make periodic reports to the State Board of Public Health.
9. Fair Hearings and Judicial Review are provided for, if required.

When matters of utilization and quality of medical care arise the evaluations must be arrived at on the basis of professional judgment. Much research has been and continues to be done to devise mechanical means at arriving at administrative methods of control of quality and utilization. None have yet reached the stage of providing professional judgment, although they can point up areas for professional judgment to be exercised. All hospitals, extended care facilities, skilled nursing homes and home health agencies are required to have utilization review committees. While members of Peer Review Committees may not feel that they have jurisdiction for facility utilization, they undoubtedly will be consulted in an informal way concerning these matters by their fellow physicians and administrators of facilities.

Peer Review Committee action will often involve knowledge of the basic program. It will therefore be important on many occasions to have present responsible persons from the administrators, particularly the fiscal administrators. I will cite a case in which there are many problems. The case is partly real and partly hypothetical.

On the advent of Medicaid in January, 1970, there were some 60 patients in a nursing home which had been rated by the health department as a skilled nursing home. On the first visit to this home by the Medicaid Nurses Evaluation team it was found that the medical records were almost non-existent. There was no indication that the patients had been visited by a physician for a considerable length of time, nor was there

any indication that the patients had been obtaining any significant medication or other therapy. This was mentioned to the chief nurse and administrator of the nursing home by the Nurses Evaluation team members, and the administrator then consulted the physician who was ordinarily called in the case of severe illness on the part of any of the patients. The doctor made a detailed examination of each patient including a considerable amount of laboratory work. A number of the patients were over 65 and thus under the jurisdiction of the Medicare program, which is administered by Blue Cross. Also, a considerable number of the patients were not eligible for the Medicare program, but came under the Medicaid program, which is administered by Equitable Life Assurance Society.

The physician submitted bills for his examinations and laboratory work which totaled somewhere in the neighborhood of $8,000. This, of course, was picked up as extremely unusual. There was considerable uniformity in the types of laboratory work performed on each patient. For example: Pap cytology studies were made on most of the women patients, even though some of the women were in the 80's. These claims have been referred to the Medical Services Administration and we have discussed the matter with the physician who states that he has cared for most patients in this nursing home over the years receiving practically no remuneration, and even has furnished medication from his own private stock from time to time. There were never any funds to remunerate him for examination or laboratory work and, thus, they were not accomplished. He feels a personal satisfaction from the examinations he has accomplished because he has uncovered such illnesses as latent syphilis, diabetes, and other diseases which can be helped with

(Continued on Next Page)

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: MRS. ELIZABETH HARKINS, ACSW, *Coordinator of Admissions*

or

SAMUEL N. WORKMAN, M. D.
Chief of Clinical Services

CHARLES W. NEVILLE, JR., M. D.
Assistant Professor of Psychiatry and Medical Director

Area Code 704 - 254-3201

therapy. He recognizes that this is an unusual situation and is anxious for the Peer Review Committee to decide what is right in order that he may decide how much of his own time to allot the patients in this nursing home.

Medicare has a ruling that it does not pay for routine physical examinations, and Blue Cross, which administers the program, is of the opinion that these were routine examinations and therefore not covered. On the other hand, it undoubtedly will be argued that the doctor certainly can maintain that these were all patients in a skilled nursing home under his care, and that he was certainly entitled to examine them and prescribe proper therapy.

The Nurses Evaluation team, on a re-visit to this nursing home, has reported much improved records, much improved care, and many patients who are without question benefiting from the recently instituted therapy.

Thus, you can see that there are many problems which Peer Review Committees must face. Were these examinations and laboratory tests necessary? Were they professionally appropriate? Is the therapy which has been prescribed proper for patients of this kind? Were the examinations covered by the law establishing the program? Were the charges correct?

One of the problems which faces the Medical Services Administration is the transfer of patients from skilled nursing care to intermediate care facilities and vice versa, and from either category of nursing care to home care. I have mentioned the Nurses Evaluation team who are attempting to classify patients into these categories. Suffice it here to say that there cannot be agreement in every case between the Medical Services Administration and the attending physician. We feel sure the Peer Review Committees will be asked to express an opinion on several of these individual problems.

Peer Review Committee action must always be considered as educational and not punitive. It is hoped that some of the cases will be sufficiently informative that they can be written up and published in the local or state medical department journals. It is hoped, also, that the actions of the Peer Committees can be discussed in the local Medical Society meetings. I want to assure you, also, that the Medical Services Administration desires to assist in every way in the administrative work concerned with the meeting of the Peer Committees, and we will attempt to have the problems in such form that they can be clearly presented to the Committee and thus minimize detailed work by the Committee members.

In closing, I want to add one personal observation. I have been in the Medicaid program here only three months. But, on the basis of my several years experience in Health Insurance, both Government and private, I want to say that you have a good Medicaid program in Alabama. Dr. Alphin and his small staff have worked diligently. It has been well conceived to build-in controls and accumulate important information. The program has some deficiencies but these are being resolved as rapidly as possible. The program is going to need professional guidance and we hope you will have personal satisfaction in giving that guidance. We hope, also, that your Peers will accept gracefully your solutions to problems.

OFFICE AVAILABLE IN MOBILE

Modern office; prime location. Available September, 1970. Approx. 1500 sq. ft. Equity sale or lease. Contact Hugh Reynolds, M. D., 1653 Spring Hill Avenue, Mobile, Alabama 36604.



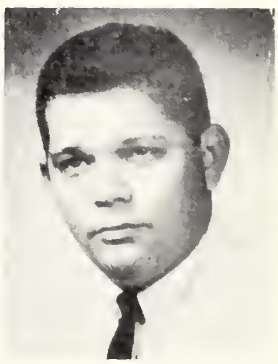
around the state

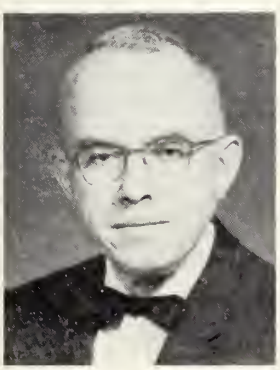
New Physicians Licensed To Practice In Alabama

Joseph Patrick Archie, Jr., M. D., University of North Carolina School of Medicine, 1968, Reciprocity with North Carolina —Intends to locate in Birmingham.



Oswald Bernard Carr, Jr., M. D., University of Mississippi School of Medicine, 1964, Reciprocity with Mississippi—Intends to locate in Sylacauga.





Peter I. Brandes, M. D., University of Michigan Medical School, 1935, Reciprocity with New York—Intends to locate in Tuscaloosa.



Andrew Grout Finlay, Jr., M. D., Tulane University School of Medicine, 1963, Reciprocity with Louisiana—Intends to locate in Albertville.

Dennis Albert Brown, M. D., University of Louisville School of Medicine, 1959, Reciprocity with Kentucky—Intends to locate in Cullman (or environs).



Bartley Richard Frueh, M. D., College of Physicians & Surgeons Columbia University, 1964, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.





Thomas Allen Gaskin, III, M. D., University of Alabama School of Medicine, 1967, Reciprocity with the National Board of Medical Examiners—Intends to locate in Birmingham.

Arthur Stanley Ludwig, Jr., M. D., St. Louis University School of Medicine, 1961, Reciprocity with National Board of Medical Examiners—Intends to locate in Birmingham.

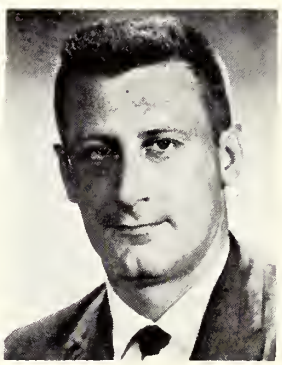
Picture Not Available

Picture Not Available

Louis Giles Horn, III, M. D., Vanderbilt University School of Medicine, 1963, Reciprocity with the National Board of Medical Examiners—Intends to locate in Huntsville.

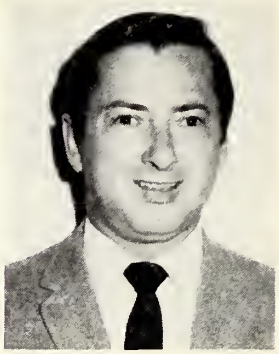


Anthony Joseph Mussallem, M. D., University of Miami School of Medicine, 1965, Reciprocity with National Board of Medical Examiners—Intends to locate in Vernon.



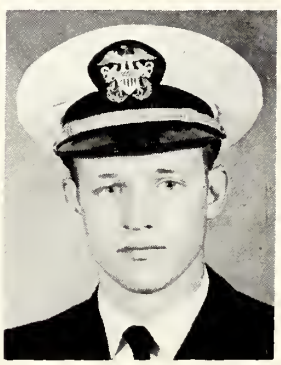
George Barry Jackson, M. D., University of Kansas School of Medicine, 1963 Reciprocity with Kansas—Intends to locate in Birmingham.

George Harry Norton, M. D., Emory University School of Medicine, 1962, Reciprocity with Georgia—Intends to locate in Opelika or Auburn.





Kenneth Robert Lee Lassiter, M. D., Duke University School of Medicine, 1961, Reciprocity with North Carolina —Intends to locate in Birmingham.



Randell Delmar Sells, M. D., University of Louisville School of Medicine, 1968, Reciprocity with Kentucky—Intends to locate in South Alabama or Decatur area.



Albert Edward Laughlin, Jr., M. D., University of Tennessee College of Medicine, 1966, Reciprocity with Mississippi—Intends to locate in Daleville.

Enoch McLain Toler, M. D., Louisiana State University School of Medicine, 1964, Reciprocity with Louisiana—Intends to locate in Mobile.

Picture Not Available



With Blue Shield's new plan to pay physicians' usual, reasonable and customary fees, your patients are far less likely to favor methods of government-controlled health care.

BLUE CROSS-BLUE SHIELD OF ALABAMA

®

Hobbies To Fill A Doctor's Leisure

Man's Best Friend As A Happytime Pursuit

Some Alabama doctors are going to the dogs . . . and finding (in the process)—fun . . . relaxation . . . and occasionally profit!

Take for example the experience of Buris R. Boshell, M. D., whose devotion to dogs was developed spectacularly with the gift of a boxer puppy while he was a postdoctoral student at Harvard. A patient gave him the puppy. He entered his gift in a dog show. First prize was awarded his entry. And there has been no relaxing of interest in dogs and dog shows since.

Born on a farm in Marion County, Oct. 9, 1926, this future authority on diabetes, Professor and Director, Division of Diabetes and Related Diseases, Medical College of Alabama, spent the first six years of his higher education at Auburn, earning a B.S. degree in Agricultural Science and spending two years in Veterinary Medicine. In pursuit of an M.D. degree he spent two years in the Medical College of Alabama, transferred to Harvard, from where he graduated in 1953. He interned and served his residency at Peter Bent Brigham Hospital, Boston, and pursued his medical career there until coming to Birmingham 11 years ago.

Dr. Boshell's interest in boxers culminated in winning the top puppy prize in America in 1954: the Grand Futurity, associated with the American Boxer Club in New York. Then, because of the size of the boxer and a decision to develop a careful breeder program, he turned to Miniature Pinschers a year before moving to Alabama. And in the decade of the 1960s his Bo-Mar Kennels have attained an unchallenged position as the outstanding producer of champions, with some 60 show-winning Miniature Pinschers to their credit. Three years ago the top five winners



Dr. Boshell

were all from these kennels and they have consistently won Best-of-Breed at America's three elite shows: Beverly Hills, Calif.; International in Chicago; Westminster in New York. More than that, Dr. Boshell has exported his dogs to Australia, Japan, Puerto Rico, Canada, South Africa, and has sold them to just about every state in the union.

Married to the former Martha Sue Johnson, June 4, 1951, the Boshells have two children: Patty, born Dec. 20, 1957, and Thomas Eppinger Boshell, whose birthday is July 31, 1963.

* * *

Dr. Boshell's commitment to canines began in his latter 20's. Another Alabama native destined for the profession of Medicine developed his devotion to dogs at a third that age, or about the time his parents permitted him to go hunting, armed for birds.

Hiliary Herbert Henderson, Jr., was born in Bolling, Alabama, near Greenville, Dec. 8, 1912, the son of a doctor, destined for his own M.D. degree. And Woodrow Wilson was still President of the United States when

(Continued on Page 1135)



What she really needs, Doctor, is a shot of penicillin.'

aybe. Maybe not. In any case she needs something to ntrol her sneezing, watery eyes and runny nose. And for ost children over six, Novahistine® LP can be depended to provide fast relief from summer colds and allergy. ese continuous-release tablets have a vasoconstrictor-tihistamine formulation that begins working in minutes, en continues to provide relief for hours. A single Nova-stine LP tablet, morning and evening, can keep most young patients free of symptoms all day and all night. Use with caution in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Novahistine® LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

DOW THE DOW CHEMICAL COMPANY Rx Pharmaceuticals Indianapolis

Clinical Extension of a pure Smooth Muscle Relaxant

TROCINATE®

Brand THIPHENAMIL HCl

400 mg./100 mg. S/C tablets

Trocinate relaxes all smooth muscles. Its direct action (musculotropic) does not involve the autonomic nervous system and it is not mydriatic. It is metabolized by the body and eliminated in the urine as harmless degradation products. Trocinate has a remarkable history of freedom from side-effects.

When a pure direct-acting smooth muscle relaxant is indicated, Trocinate is the drug of choice.

DIARRHEA (functional) . . . *the first 400 mg. tablet usually relieves the discomfort of diarrhea so promptly that it ceases to be a bother.*

DIVERTICULITIS—MUCOUS COLITIS . . . *the accompanying discomforts can be relieved by this direct smooth muscle relaxant.*

BLADDER SPASM . . . *relaxation is immediate. One or two tablets condition the bladder for cystoscopy in one hour.*

SPASTIC URETER . . . *the specific relaxing effect of Trocinate on the spastic ureter has been proven by animal studies and affirmed clinically. (J. Urol. 73:487-93)*

PRESCRIBING INFORMATION

WARNING: Do not give in advanced kidney or liver disease. PRECAUTIONS: Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. DOSAGE: 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

NOTE: *The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between dosage rather than lessening the recommended dose is preferable. The prompt direct action allows a consciousness of the first suggestion of return of symptom . . . a guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a reserve.*

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of Ethical Pharmaceuticals

(Continued from Page 1132)

he first ventured into the pastures in pursuit of whatever birds came within the sights and range of his BB gun. He would progress from there to the pellet-packed shotgun shell via the old reliable .22, inevitably accompanied by his dog.

Hunting dogs have absorbed his leisure interest since then—fine setters and pointers today; whatyumacallits yesterday.

From Butler County High School, the future Birmingham surgeon went to the University of Alabama for his baccalaureate and to Tulane for his M.D., returning to Birmingham's Hillman and Fairfield's Lloyd Noland for his internship and residency.





Dr. Henderson is married to the former Margaret Bissell of Birmingham and they have three sons—Hilary III, 24; David, 19; Brooks, 13—not one of whom plans to provide a third generation qualifying for The Journal's *Fathers-and-Sons-in-Medicine.*

* * *

A broken neck put Dr. Edgar Scott of Birmingham in bed for two years and just about wrote "The End" to a career in Proctology and General Surgery. But Dr. Scott represents that great "silent majority" of medicine, interested in man's-best-friend primarily as the household pet.

In his instance, it has been Boxers.

Born May 16, 1907, Edgar Scott earned his Master's in Sociology at the University of Alabama before going on to Harvard, where he obtained his M.D. degree in 1934. World War II saw him an Army officer practicing general surgery in the nation's military hospitals.

Afterward he returned to Birmingham, built a small hospital and clinic, and seemed well on his way to a successful career in his chosen profession when his unwary foot caught on a close-to-the-ground fence and the fall snapped a vertebra in his neck.

* * *

As a "clincher" entry in this dogs-for-a-hobby to fill a doctor's leisure, let's go to Brewton, the county seat of Escambia, in the Coastal Plain region of South Alabama, just seven miles above the Florida line, and in the heart of the Conecuh-Escambia river watershed.

From here came Ch. Satilla Virginia Lady, the exquisite National Champion of three years ago. This aristocrat of the bird season was the unanimous choice of the judges, out of a field of the nation's best, competing in that keenly polished, tightly competitive professional event at Grand Junction, Tenn.



Ch. Satilla Virginia Lady was the proud possession of Frank Marion Phillippi, Jr., M. D., Brewton General Practitioner, vice president for the Southwestern quarter of Alabama for the Medical Association, and Director for the 2nd Congressional District

for ALAPAC (the Alabama Medical Political Action Committee).

ALAPAC Director Phillippi was born Dec. 22, 1915—on the 219th birthday of James E. Oglethorpe, founder of Georgia. Greenville, South Carolina, was the town of his nativity, though his family moved to Camden, Alabama, when he was still a small child. From high school, he went to Auburn for his baccalaureate and to Tulane for his M.D., interning at Charity Hospital in New Orleans.

He is married to the former Virginia Kerlin of Mobile and there are two sons: Frank M. Phillippi III (much better known as "Bucky"), 18, who goes to Auburn next semester on an athletic scholarship, planning to major in wildlife biology, and George McCown Phillippi, 17, also a football player, finishing high school next year. "Mac" is his nickname.

As a boy in Camden, Dr. Phillippi had dogs, but they were a far cry from the sleek championship material of now. In those times—in the period of World War I and beyond—he had coon hounds. And naturally, as coon hunting was a favored sport thereabouts.

It was not more than 20 years ago that Dr. Phillippi turned to much more aristocratic bird hunting, and the complexion of his dogs changed accordingly. Today his onetime Queen of the Hunt, "Lady," has been retired to the Phillippi home as a pet, along with several of her registered puppies.

One of these puppies, however, has been left in training under the same competent trainer-handler who guided the mother to a championship at Grand Junction. He is Herman Smith of Hatchechubbee, Alabama.

DOCTORS
Who Play With Fire
(Their Favorite Recipes)

Oyster Foch:

To four ounces of Hollandaise Sauce (prepared from dehydrated preparation available in groceries), add two tablespoonsful of Catsup, several dashes of Worcestershire Sauce, one ounce of kitchen Bouquet, and two ounces of Cream Sherry. This makes a hot thick brown sauce to be poured liberally over:

Fried oysters prepared in an egg batter with a thin crust from the addition of Pancake flour and placed on rounds of Holland Rusk, with or without a layer of Pate. Four or five oysters make an adequate serving.

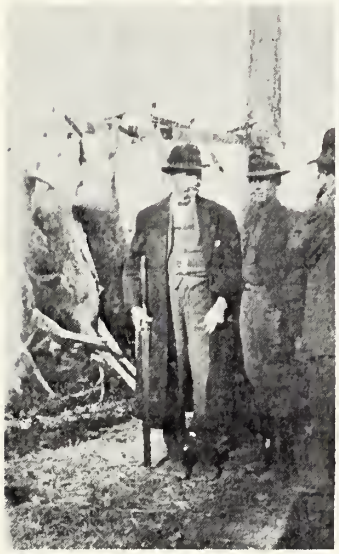
(This is my modification of a New Orleans recipe from Antoine's, and the quantity of ingredients listed is approximate, as I am a "tasten" cook, adding a little more or less to suit me).

—Jack Hyman, M.D.
Mobile

Con-
ven-
ience!
Dicarbosil®
ANTACID
Your ulcer patients and others will praise it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.
ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

Fathers and Sons in Medicine

Four Doctors And 120 Years In Medical-Practice History









A FADED PHOTOGRAPH is the only surviving likeness of Robert Hadden Hale, M. D. (1850-1931), a picture taken around the turn of the century showing him with his gun and standing beside his eldest son, Robert Eugene Hale, M. D. (1874-1955). The deer they killed have faded from the background of the picture . . . A better likeness of this eldest son is next . . . William Alexander Hale, M. D. (1884-1936) is third in line, above . . . And finally is the surviving subject of this feature, Robert Carl Hill, M. D. (1894-), grandson of Dr. Robert Hadden Hale.

A favorite 8th-grade assignment in Sumter County High School is the life sketch of a local personality. And a favorite subject for these essays is the senior of six members of the Sumter County Medical Society, 76-year-old Robert Carl Hill, M.D., of York.

Nor could one imagine a more appropriate subject than this one-man Senior Class of 1911, the first person to receive a diploma from the then new Sumter County High, the grandson of one, the nephew of two physicians prominent locally.

The history of the Hales and the Hills in medicine in western Alabama begins with the birth Sept. 25, 1850, of Robert Hadden Hale. Named for a prominent minister of that day, young Hale first determined to become a Presbyterian preacher, but abandoned this objective when he met and married Mary Catherine McDonald just five days before his 21st birthday.

Two children—Mattie Elvyn and Robert Eugene—were born of this marriage, one of whom would become the mother of a doctor, and the other a physician whose memory is perpetuated in the Tuberculosis Sanitarium at Tuscaloosa, which bears his name.

It was not until after Catherine's death that Robert Hadden Hale decided to study medicine, attending school in Louisville, Ky., from where he obtained his M.D. degree in 1879. He practiced in Livingston two years before moving to York and marrying Elizabeth Carr of Pushmataha, over in Choctaw County. This was the same year in which Garfield was assassinated, that the American National Red Cross was organized by Clara Barton, that Coney Island first became a fun capital, and that Tuskegee Institute was established.

The Carr family had long been prominent in medicine. And so it was significant that of the two sons born of this marriage, William Alexander Hale should choose medicine for a career and pursue it through the rest of his mature life.

With the lapse of time after the death of his second wife, Dr. Hale married Beulah Ar-

rington, member of a prominent Sumter County family that numbered in its fold two prominent Alabama physicians. One daughter born of this marriage still resides in York.

Dr. Robert Hadden Hale died in York Oct. 2, 1931, just six days after his 81st birthday.

His eldest son, Robert Eugene, born Nov. 17, 1874, became a printer and county newspaper published before deciding that the Fourth Estate was not for him. He went to St. Louis to study medicine, in the midst of which the Spanish-American War called him to the service of his country. He was still in service in 1904 when he graduated in medicine in Chattanooga. About this time he met and married Harriett Cornelia Spear of Portland, Maine, and practiced medicine in Bellamy, Sumter County, to the day of his death October 24, 1955, just three weeks short of his 81st birthday—and except for the interruption of World War I, when he went back into service and served as Adjutant to the Hospital Center at Rimacourt, France, wearing the oak leaves of a major on his shoulders. This Dr. Hale and his wife had no children, and he did not remarry after her death in 1931.

William Alexander Hale, born of the second marriage of Dr. Robert Hadden Hale, chose medicine for a career early in life, following his half-brother to an M. D. degree in Chattanooga in 1906, and devoting the remaining 30 years of life left to him to his practice. For a short time he was in practice in Bellamy with his brother before moving on to a more expanded practice in Mobile, where he also owned a drug store.

Dr. William Alexander Hale married Irene Bosarge, member of a pioneer Bayou la Batre family. There were no children. And Mrs. Hale survived her husband many years, dividing her time between their homes in Mobile and Bayou la Batre.

As for the concluding subject of this family whose connections in medical history extend back to colonial days, Robert Carl Hill is a nephew of the two doctors in the immediately preceding paragraphs, the son of Mattie Elvyn (Hale) and Benjamin Robert Hill, born on Thursday, Feb. 1, 1894.

Although he took a circuitous path to a career in medicine, by way of a degree in pharmacy, this latter-day doctor of the Hale-Hill family was his grandfather's assistant in minor surgery when he was 12 years old. Dr. Hale's front porch doubled for an operating room and his grandson's job was to administer chloroform to the patient stretched on a bench. The patient's job, after he recovered consciousness, was invariably to clean up the scene of his recent surgery, washing the floor clear of bloodstains.

Not only pharmaceuticals but war postponed pursuit of an M.D. degree. He enlisted "for the duration" in the Medical Corps less than two months after we entered World War I and, true to army tradition, became a cook! Which is no way to develop enthusiasm for food preparation as a hobby in mature life. Dr. Hill was not among those listed in the published feature "Hobbies to Fill a Doctor's Leisure—Cooking." He went to France where he collected many memories to spice his repertoire in later life and left the Army Aug. 11, 1919, with the rank of Master Hospital Sergeant.

After the Army he became an assistant to his Uncle, Dr. R. E. Hale, who was physician for the Allison Lumber Company at Bellamy, in the fall of 1920 enrolling in the premed course at Tulane, from where he graduated with his M.D. degree in June, 1925. The next year he married Emily McClinton, a registered graduate nurse, and in his letter to me he added: "We have been full partners in all our work for the 40-odd years since," beginning when she attended the Lakeside Hospital School of Anaesthesia while he was taking advanced work at the New York Post Graduate Hospital.

In 1931 they moved to York, dividing their time between practice and minor surgery in their office there and major surgery in the Bellamy Hospital. Then, 20 years ago while

walking through the azalea garden of a friend, Dr. Hill had the first twinges of chest pains that developed during the night into a full-scale coronary upset. This combined with a cataract persuaded this husband-and-wife medical team to sell their hospital, and medical practice in the decade of the '60s has been largely coincindental.

Today, Dr. and Mrs. Robert Carl Hill's home in York is within a block of the house where he was born 76 years ago, proud of such honors as come to their foster son, Charles Hill Munoz, of the fact that Dr. Hill is a Life Counsellor of the Medical Association of the State of Alabama, that he is a charter member of the Alabama Gynecological and Obstetrical Society, of all the other recognized professional groups, and very especially of the fact that the young people of Sumter County High's eighth grade find him a happy subject for their English-class essays.

When Alabama Knew Three Doctors "Jimmy" Watkins

Faced with the ever expanding limits of longevity, the world may thank medicine for it.

But, in the lives of many physicians, one is reminded of the passage from St. Matthew: "He saved others; himself he cannot save."

The fact is no better illustrated than in the life stories of a father, a son, and a grandson—all Alabama doctors. The first of the trio was in his 60s when he died, the second in his 40s, the third in his 30s. But each in turn left a glowing passage in the pages of Alabama medical history.



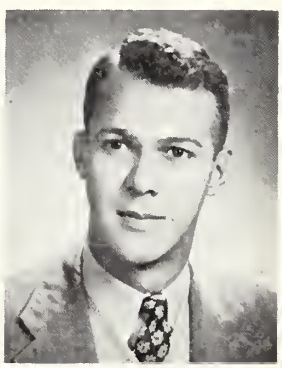
Dr. J. M. Watkins

To the younger of the three—James Harold Watkins, Jr.—his godfather, Dr. Alton Ochsner of New Orleans paid this unqualified tribute:

"In his short life, Jimmy gave more help, more hope and more love to more people than most doctors do in their three score and ten years."



Dr. J. H. Watkins, Sr.



Dr. J. H. Watkins, Jr.

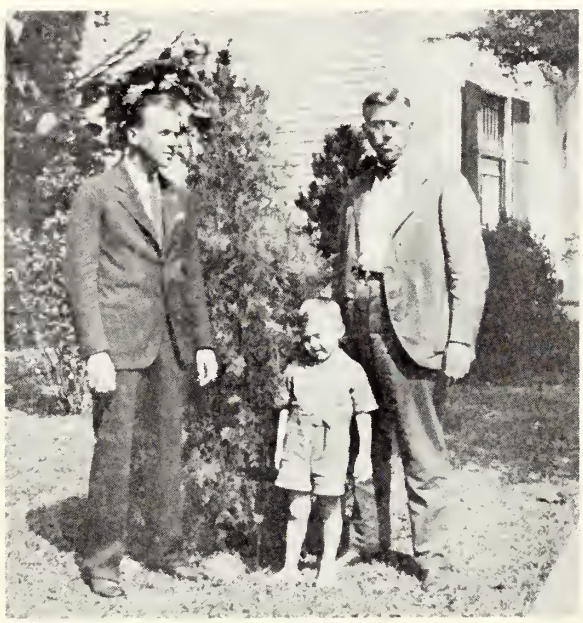
But to begin at the beginning:

James Monroe Watkins ("Big Jim" to his grandson, Jimmy) was born Dec. 16, 1870 on a farm near Troy, Alabama, in Pike County. His early education was obtained at Highland Home Academy at the Crenshaw County town of that name, a school owned and operated by the father of Prof. Ellie Barnes of Montgomery, whose famous Barnes School for Boys was destined later to earn an element of local fame. He was graduated from the Vanderbilt School of Medicine in 1892, and had postgraduate work in surgery in New York City and London before the turn of the century.

Dr. "Big Jim" Watkins began his medical

practice in the horseback-and-saddlebag days of the Gay Nineties in Tarentum, in Pike County, which is no longer a postoffice. In 1895 he moved to Troy, marrying Belle Gillis of that city. There were two children: Esten, Mrs. Frank Rosa of Prattville, and his doctor son, James Harold Watkins, Sr.

Dr. "Big Jim" has been described by those who remember him as a very dynamic personality, tall, handsome, talented, outgoing and much beloved. He died at Hubbard Hospital in Montgomery Jan. 25, 1932, of a coronary occlusion—foreshadowing precisely what would happen to his grandson just 28 years later.



THREE GENERATIONS OF DOCTORS (1928).——James Harold Watkins, M. D., James Harold Watkins, Jr., M. D., and James Monroe Watkins, M. D., in that order, in a photograph taken in Troy, Ala.

This elder Dr. Watkins' son, James Harold Watkins, was born in Troy Nov. 17, 1903. He attended the public schools of Troy and was graduated from Marion Military Institute, in June, 1921. Earning his baccalaureate from the University of Alabama in 1925, his M.D. degree from Tulane two years later, he interned at Hillman Hospital, Birmingham, and served his residency at the Joseph R. Pratt Diagnostic Hospital in Boston. In that latter time he was a visiting physician at Massachusetts General Hospital and at the Peter Bent Brigham Hospital.

In the early part of his career he taught and did research in the Tulane Department of Medicine, collaborating with Dr. John Herr Musser in writing the chapter on Diphtheria for *Blumers Bedside Diagnosis,* a favored textbook of that time. War took Harold into the service of his country and overseas, serving in the North African and Italian Theaters from 1942 to 1945, latterly as Chief of Medicine of the 24th General Hospital, the Tulane unit. This was the largest hospital we had overseas, established in Florence, Italy, with 3,000 beds. Attached to the 5th Army, Dr. Watkins received many citations and decorations, retiring at war's end with the rank of colonel.

Married to the former Merle Martin of Birmingham, there were four children: James Harold, Jr., Mason Martin, Merle Musser, and John Francis. John Francis Watkins, the youngest was still a student at Virginia Military Institute when he died, not a great while after his father's life was cut short by an automobile accident at the century's halfway mark, 1950, when Dr. J. Harold Watkins was still shy of his 47th birthday.

What Montgomery thought of Harold Watkins is well attested by an editorial in the Alabama Journal of May 1, 1950, in which Editor C. M. Stanley wrote: ". . . While he was a specialist in medicine, this man gave his patients those qualities of human warmth, interest and kindness that are generally associated with the oldtime 'family physician.' It can safely be said that the patients served by Harold Watkins not only trusted him —they loved him . . . Harold Watkins will need no monument where he is laid to rest. He built it in the hearts of thousands of men and women while he lived."

Finally, the grandson, James Harold Watkins, Jr., was born Sept. 13, 1925. Appropriately, he was graduated from the Barnes

School in Montgomery, under the tutelage of the son of the educator who had taught his grandfather. Appointed from Alabama, this Jimmy Watkins went on to the United States Naval Academy at Annapolis, graduating in the Class of 1947. After service aboard the Carrier Franklin D. Roosevelt, he resigned his commission in 1948 to earn a second B. S. degree, this time in biology and chemistry, at the University of Alabama, before beginning medicine at Tulane, where he was a freshman when his father lost his life.

My own editorial-page column ("As I See It") carried in advance the announcement that a Watkins was returning to Montgomery's medical roster. This was the summer of 1957. Three years later—Aug. 11, 1960—he was dead of a coronary occlusion, the identical kind of attack that took his grandfather 28 years before.

James Harold Watkins, Jr., Ensign, USN, was married in the Naval Academy Chapel, Annapolis, to Carolyn McCrummin of Montgomery, following his June graduation. As the newlyweds were under navy orders, their return to Montgomery was by way of Jacksonville, six weeks later. And so the picture of them packing their car, published in The Advertiser's Promenader-by-Go Peep on a Sunday in August was not actually a honeymoon picture.

In addition to his widow, the younger of this trio of Drs. Watkins is survived by two daughters, Lynn and Sara. The latter on the 20th of this month was to become Mrs. Woodley Bagwell.

—W. J. M., Jr.

We have a saying in our laboratory that the difficulty of a project goes from "Nobel Prize" to "M.Sc." in about 5 to 10 years!

—Francis H. C. Crick, Nobel Laureate in Medicine and Physiology, 1962

—Rhode Island Medical Journal

Diabetes Specialists Speak In Birmingham

Diabetes of Yesteryear, Diabetes Today and Diabetes Tomorrow is the subject of a program to be held on Tuesday, June 30th, in the Engineering Auditorium of the University of Alabama Medical Center, 1918 8th Avenue South, Birmingham.

Speakers will include Dr. David Kipnis, Washington University, St. Louis; Dr. George Cahill, Harvard University, Boston; Dr. Alexander Marble, Director, Joslin Clinic; Dr. Stefan Fajans, Professor of Medicine, University of Michigan, Ann Arbor; Dr. Albert I. Winegrad, Professor of Medicine, University of Pennsylvania; Dr. R. N. Schimke, Geneticist, University of Kansas. Also invited to speak, but at the Journal's press time unconfirmed, are: Dr. Albert Renold, Geneva, Switzerland, and Dr. Robert H. Williams of Seattle, Wash.

Dr. Buris R. Boshell, Ruth Lawson Hanson Professor of Medicine and Director of the Division of Diabetes and Related Diseases, Medical College of Alabama, announced the program.

One Sentence Essays

To one brought up in the old tradition when, for example, fractures and osteomyelitis and bone tumors were the domain of the general surgeon, when jaw resections and radical neck resections dismayed and repelled the plastic surgeons, when the "brain team" experience was a standard part of the surgeon's training, and viscera within the chest as much a part of his domain as those within the adbomen—or pelvis—there is a sense of sadness about the progressive constriction of general surgery.

—Mark M. Ravitch, M.D.

AMA Annual Convention In Chicago June 21-25

Chicago, the city with a proven knack for news and a demonstrable warmth of reception for all, will host the 119th Annual Convention of the American Medical Association June 21-25.

Combining the world's largest medical meeting with the nation's convention capital provides the ideal opportunity to present a comprehensive scientific program in incomparable facilities. For the "medical family," it will all be there—postgraduate education presentations for physicians, c o m m u n i t y service stimuli for their wives in the Woman's Auxiliary's concomitant meeting, and recreational diversions for their sons and daughters.

The hub of the Scientific Program (which will be published in its entirety in the May 4 issue of *JAMA*) will be the International Amphitheatre on Chicago's Near South Side. This huge complex, site of many of America's most memorable political conventions, is fully air conditioned and its expanse permits presenting the entire AMA scientific program on one floor under one roof.

Over 10,000 physicians in general practice and all the specialties are expected to attend, together with another 20,000 allied health professionals and guests.

Approximately 450 scientific and industrial exhibits will be staffed by pharmaceutical manufacturers and suppliers of medical materials and services and by many of the world's most prominent medical researchers and practitioners. All 23 sections of the Scientific Assembly will be represented. Four general scientific meetings will be addressed to Coma and the Diagnosis of Death, Conception Control and Abortion, The Role of Allied Health Professions in the Delivery of Health Care, and Family Life and the Physician.

Among the special exhibits will be fresh tissue pathology, fractures, pulmonary function, resuscitation, arthritis, and laboratory medicine.

Seven sessions under the Section of Special Topics will cover suicide, adverse reactions, drug interactions, neurological surgery, occupational diseases, plastic and maxillofacial surgery, and nuclear medicine. In addition, the 10th Multidiscipline Research Forum will present 50 papers prepared by prominent scientists.

The AMA Annual Convention is also the time for honoring those who have made major contributions to medicine. Among the citations to be conferred are the Hektoen and Billings Awards, the Joseph Goldberger Award in Clinical Nutrition, the Distinguished Service Award, the Scientific Achievement Award, and the Citation of a Layman for Distinguished Service.

The scientific program will also feature an extensive motion picture program, the high school student winners of AMA honors for their exhibits presented at the 1970 International Science Fair, and the winning exhibitors from the Student American Medical Association competition. The Fireside Grand Rounds are still another outstanding opportunity for physicians to discuss medical interests with eminent colleagues.

Hours of attendance at the Amphitheatre will be 10 a.m. to 5 p.m. on the opening day, Sunday, June 21, and from 8:30 a.m. to 5 p.m. on successive days to the closing on Thursday, June 25.

A special consideration is that physicians *only* will be admitted in the Amphitheatre up to 12 noon on *Tuesday, Wednesday and Thursday.* This provision will permit physicians to visit at greater length with exhibitors and concentrate upon the special features, lectures, and other scientific programs.

Another service provided by the AMA will be free bus transportation between major

(Continued on Page 1145)

IN ASTHMA
IN EMPHYSEMA



optional therapy

THE mudranes®

All Mudranes are bronchodilator-mucolytic in action, and are indicated for symptomatic relief of bronchial asthma, emphysema, bronchiectasis and chronic bronchitis. **MUDRANE tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **Iodide side-effects:** May cause nausea. Very long use may cause goiter. Discontinue if symptoms of iodism develop. **Iodide contraindications:** Tuberculosis; pregnancy (to protect the fetus against possible depression of thyroid activity). **MUDRANE-2 tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline. **Iodide side-effects and contraindications are listed above. MUDRANE GG tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **MUDRANE GG-2 tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions:** Those for aminophylline. **MUDRANE GG Elixir.** Each teaspoonful (5 cc) contains 26 mg. glyceryl guaiacolate; 20 mg. theophylline; 5.4 mg. phenobarbital (Warning: may be habit-forming); 4 mg. ephedrine HCl. **Dosage:** Children, 1 cc for each 10 lbs. of body weight; one teaspoonful (5 cc) for a 50 lb. child. Dose may be repeated 3 or 4 times a day. Adult, one tablespoonful, 4 times daily. All doses should be followed with ½ to full glass of water. **Precautions:** See those listed above for Mudrane GG tablets.

MUDRANE—original formula
First choice

MUDRANE-2
When ephedrine is too exciting or is contraindicated

MUDRANE GG
During pregnancy or when K.I. is contraindicated or not tolerated

MUDRANE GG-2
A counterpart for Mudrane-2

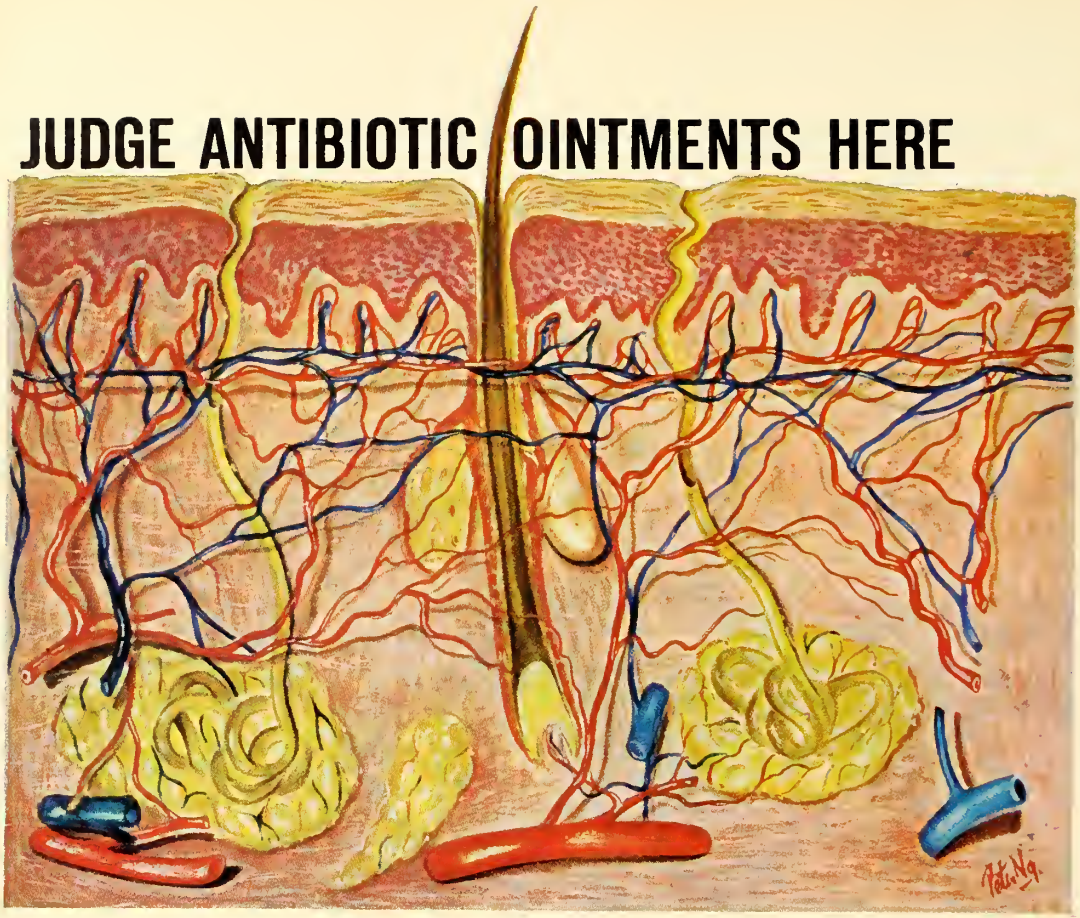
MUDRANE GG ELIXIR
For pediatric use or where liquids are preferred

Clinical specimens available to physicians.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

(Continued from Page 1142)

downtown hotels and the Amphitheatre each day. The shuttles will operate from 9 a.m. to 3:30 p.m. Sunday and from 8:30 a.m. to 3:30 p.m. on following days to the Amphitheatre; the return schedule to hotels from the Amphitheatre will be 9:30 a.m. to 6 p.m., Sunday, and 8:30 a.m. to 6 p.m. thereafter. Still another transportation convenience will be provided on Wednesday and Thursday for departing registrants: the Continental Air Transport Company will schedule bus service at 30 minute intervals from the Amphitheatre direct to O'Hare International Airport at $2 per person. On Wednesday, the buses will operate between 2:30 and 5 p.m. and from 2 to 4:30 p.m. on Thursday.

Physicians who find they have too many bases to cover can be well-briefed on the meeting highlights by viewing the special closed circuit TV programs transmitted to sets in downtown hotel rooms. The telecasts will present major news of the scientific program, actions of the AMA House of Delegates, special events, and topics for women's interest. The telecasts will be presented in color for the first time this year. Viewing hours will be: Sunday, 5 p.m.-midnight; Monday through Wednesday, 7-9 a.m., 5 p.m.-midnight, and Thursday, 7-9 a.m. In addition, the convention's *Daily Bulletin* will be published and distributed in hotels throughout the week.

Receptions, luncheons and dinners for alumni organizations and specialty groups will abound and these "timetables" were carried in *JAMA* May 4.

Among the most colorful programs during the Convention will be opening of the AMA House of Delegates at 2 p.m., Sunday, in the Grand Ballroom of the Palmer House, and the Inaugural Ceremony installing Walter C. Bornemeier, M.D., as the Association's 124th president, also in the Ballroom at 5 p.m., Wednesday, followed by the President's Reception at 6 p.m. in the Monroe and Adams Rooms of the Palmer House.

The House of Delegates will meet each day in the Palmer House, except on Monday when the reference committees discuss resolutions introduced by the state delegations.

The Woman's Auxiliary to the AMA will hold its 47th Annual Convention Sunday through Wednesday at the Drake Hotel.

Chicago is a popular summer vacation city, and the special program for youngsters and teenagers of medical families promises a memorable and educational visit. Several exciting tours, all departing from and returning to the Drake Hotel, include swim and sightseeing parties, a theater-dinner night at a country playhouse, tours to museums, zoos, newspaper plants, the police academy, the Board of Trade and the University of Chicago campus, and boat cruises on Chicago's magnificent lakefront.

For each physician's convenience, advance registration forms are being published periodically in *JAMA*. There is no advance registration for Auxiliarians, but the desk will open at 11 a.m. in the Drake Hotel, Sunday, June 21. Information on youth activities programs is being sent to officers of state and county Auxiliaries for relay to their memberships.

University Life

As individuals our active participation in university life is made easy because the community is small. The broadening influence of association with many actively thinking people in remote and near fields of interest is stimulating. It exemplifies on a small scale the wide ramifications of the social responsibilities of physicians and their impact on society. Today a cardinal need is that people generally have a better understanding than they do of medical education, practice and research. If this does not come from the teachers, it will not come at all.—William B. Bean, M.D., *Journal of Medical Education.*

From Medicine's Yesterdays To Medicine's Tomorrows

—Dr. Tinsley Harrison Takes a Look

"The medical tree has three roots," Tinsley R. Harrison, M.D., distinguished professor at the University of Alabama and specialist in cardiovascular disease, told a SAMA audience in Birmingham in an address reproduced in full in a recent issue of *Modern Medicine*, a national magazine.

Of the three, the oldest and deepest root is the priesthood, he continued, from which our profession emerged in the temples of Egypt.

As late as the time of Hippocrates, patients were treated in temples dedicated to Aesculapius, despite the beginning of the growth of the second root. This was the art or the skill of medicine, and it involved the history and the physical examination supplemented by certain crude surgical procedures. Even though Pythagoras and later Aristotle, disagreeing with Hippocrates and with Plato, proclaimed medicine to be a science rather than an art, the science of medicine was not truly born until the Renaissance. Thus, the scientific root, while now the thickest, is the shallowest by about two thousand years when compared with the art root and by four thousand years when compared with the priesthood root.



Dr. Harrison

In some countries, such as Great Britain, medical schools appeared mainly in relation to hospitals, while in others, such as Germany, they developed as integral parts of universities. The logical consequence was that, despite any number of individual exceptions, Germany trained more outstanding medical scientists while Britain produced a larger number of distinguished physicians.

During our colonial period and for several decades thereafter, the great majority of physicians in the United States were trained by the apprentice system. Under optimal conditions, which very rarely existed, the combination of a master teacher with an ideal pupil possibly provided the best type of medical education that has ever existed. But the usual result was such an inferior product that this unorganized, unsupervised method was gradually supplanted by formal courses conducted at so-called m e d i c a l schools. Most "medical schools" were mere diploma mills where poorly qualified students were indoctrinated by oratorical lectures "full of sound and fury, signifying nothing" to continue the same low level of medical care practiced by their unqualified teachers.

Then came the revolution in the form of the report by Abraham Flexner. The diploma mills were closed. An educational program well adapted to the time, the second decade of the current century, appeared on the scene. Full-time teachers were secured in the preclinical departments, and slowly, after bitter battles with the older generation, a few full-time clinical teachers were appointed. These teachers, working hand in hand with a young, vigorous, and now well-trained group of volunteer teachers, began to provide, for the first time in our national history, first-class clinical training throughout the country.

Then a surprising phenomenon occurred. The full-time teachers, both clinical and preclinical, were so pleased with the new Flexner system that they developed professional schizophrenia. As individuals, they were and still are as fine a group as one encounters anywhere. As investigators and as teachers,

many were outstanding. But as educational planners, they fell into a slumber so profound and so prolonged that Rip Van Winkle was, by comparison, a mere catnapper.

There have been two world wars since the Flexner report. Ancient dynasties have collapsed. Well nigh half the world has adopted a new—and to many of us a frightening—economic system. Dictators have come and gone. The atom has been split and the moon circumnavigated. But that Rock of Gibraltar, the medical curriculum, has stood fast, neither eroded by the rains of progress nor crumbled by the winds of change.

Little more than five years ago, the educational program at nearly all of the medical schools in the United States was almost identical with that which I pursued as a student 50 years ago. During that half century, medicine has probably advanced more, both in basic knowledge and in what we now can do to prevent and combat disease, than in all preceding time. Profound sociologic and economic as well as scientific changes have occurred. Is it not a paradox that during this same period the educational program has remained almost entirely unaltered? Is it because our faculties believe, like Candide, that we live in the best of all possible medical educational worlds? Or are our faculties, in their resistance to change, following the practice that was once ascribed to the French General Staff: "They are actively and energetically training future armies to fight past wars"?

It should be emphasized that the implications of these remarks are aimed at all medical schools. Indeed, there is strong reason to hope and some to believe that the Rip Van Winkles are beginning to start to commence to awaken. A few faculties, but as yet too few, are already awake. Hopefully, and probably, the brightness of the light of medical science plus the growing din of a complaining profession and a dissatisfied public will soon awaken all.

If we make the optimistic assumption that future educational programs should be aimed toward 1980 rather than 1920, certain questions arise. Many will naturally ask, "What definite changes would you advocate?" However, a detailed attempt to answer this question is analogous to planning specific battles before deciding on campaign strategy. Perhaps we should first take the broad view and consider aims and objectives.

Our first aims should be toward strengthening and nourishing the three roots of the medical tree. The priesthood root involves the inculcation of attitudes of dedication to patients and of strong responsibility for them. This requires early but limited contact with patients who are far more important than teachers or books as a motivating influence on students. We, as teachers, should never speak or even think of patients as "cases." Our interest and enthusiasm should be primarily directed warmly toward the patient who presents the problem, not coldly toward the problem the patient presents. Hazardous procedures are not justified for research alone or even for precise diagnosis unless there is a reasonable possibility that the information to be gained will favorably influence the treatment of the individual involved in the procedure. By example, we should teach our students that a cured patient, even though at times, without a proven diagnosis, is much more to be desired than the most brilliant diagnosis confirmed at autopsy.

Perhaps the most important means of encouraging the development of feelings of dedication to patients and of strong responsibility for them lies in developing an opportunity for close personal association between our students and those teachers who themselves display these qualities. We need think only of the impact that William Osler and Francis Peabody had on their pupils. When undergraduate classes are large, even the best clinical department chairman can establish the optimal type of personal asso-

ciation only with their interns and residents. Even then, the time may be too late. The house officer's reactions may have been already canalized by his earlier contact with less desirable teachers who regard any emotional reaction of physician toward patient or of teacher toward student as "dangerous to clear and objective thinking." Such a view is not only arrant nonsense but reveals a profound ignorance of the origin of the oldest root of the medical tree.

Every faculty has on it a few Sir Galahads. All efforts should be made toward developing maximal association between them and small groups of students. This is far preferable to the usual tutorial system in which the emphasis is toward selecting the tutor on the basis of what he *knows* rather than what he *is*. That teacher who is interested only in planting knowledge in his students' heads has missed the greatest satisfaction of his profession. The true reward stems from transplanting himself into their hearts and receiving a similar gift from them. It was this quality that made William Osler the supreme teacher of our times.

Much needs to be done toward strengthening the art root of the medical tree. The surgical techniques are necessarily to be regarded as belonging mainly to the postgraduate period. But this is not true of those bedside skills which every physician employs daily. Association with our own students and with those at other schools has led me to believe that, by and large, the subject of physical diagnosis is being taught fairly well. But the same is not—most emphatically not —true of history-taking, despite g e n e r a l agreement that, in the broad sense, the history provides more useful information than all other methods combined. It is in their woeful neglect of emphasis upon the importance of the analysis of the subjective manifestations of disease that our faculties, and perhaps especially those in departments of internal medicine, display their greatest dereliction. Each of us should have engraved upon the foremost part of his frontal lobes these words:

They look upon the instrument as all sufficient . . . they neglect or disdain to make those careful and minute inquiries which no sound and sensible physician ever fails to do, and thereby convert an invaluable auxiliary into what, in their hands at least, proves but an imperfect and treacherous substitute.

One might suspect that this statement was made in the present century in reference to the X-ray or the electrocardiograph. Actually, it was made by Thomas Addison in 1846 concerning the stethoscope. His opinion that this relatively new tool was "invaluable" provided it did not lead to neglect of "those careful and minute inquiries" is applicable to every new diagnostic procedure. In our justifiable enthusiasm for newer methods that are often very useful in research and also contribute to better patient care, we have too often subconsciously deemphasized the importance of the history. The need is urgent for correction of this defect in our clinical teaching.

More emphasis on the older roots need not mean less attention to the scientific root. Certain fundamental principles, such as those involved in the shape of the oxygen dissociation curve, in the Gamble diagrams of electrolyte composition of body fluids, in Starling's law of the heart, etc., are so important that they cannot be overemphasized. But this does not mean that the poor, suffering student needs to remember the precise levels of oxygen tension at which the dissociation curve becomes relatively vertical or the exact content of each electrolyte in normal intracellular fluid. The explosive advance of scientific knowledge has led to a situation in which any attempt to crowd into his limited cranial cavity all of the details which "it would be nice for him to know" is likely to lead to pressure atrophy of his cortex. If we omit the details, we shall have more time to stress the principles. There will also be more

time for those of the students who so desire to achive familiarity, through research, with the scientific method of thinking which, properly used, can be of great value in the care of patients.

It is not possible to even attempt to teach each student all there is to know about each and every disease. No individual teacher—indeed, no entire faculty—possesses such extensive knowledge and no student's mind could retain it. What we should do is to make certain that our students have, by the time of graduation, a reasonable familiarity with the common diseases and a knowledge of how to go about seeking information concerning the rarer disorders when they are encountered. Some months ago I saw a student who knew more about the carcinoid syndrome than about myocardial infarction. He said that he had received more teaching about the former than the latter. Another student told me that he had seen more patients with myocardial infarction during two months at a small 80-bed community hospital than in two years at University and Veterans Administration hospitals. Perhaps our policies concerning patient admission and teaching time should be devoted somewhat more to what will be of the greatest long-range benefit to the public. Such a view implies only a proper balance and in no wise means that admissions for research purposes should be curtailed. Such curtailment would be contrary to the public interest.

Another objective should be emphasis on the prevention of disease in adults by the practicing physician. We teachers of internal medicine tend, too much, to identify preventive medicine with public health. We admire the pediatricians for their effective efforts toward prevention of infections and of nutritional disorders in their young patients and praise the gynecologists for their cancer detection programs. But we do not follow their examples. How many of us stress to our students that we already have the knowhow to delay, at the least, or prevent, at the most, the onslaught of atherosclerosis and that every young adult patient should be advised accordingly? Do we even hint to our house staffs that investing one-half of the time currently spent in ordering unnecessary laboratory procedures in instruction in antiatheromatous procedures would yield high health dividends? Can we blame the practicing physician for not doing what he was never taught to do? We are proud because our medical education is good when compared with that in other countries or in the past in our own nation. But how many of us honestly admit to ourselves that, properly judged by the standard of what it could and should be, our teaching is very inferior?

Still another aim should be toward making learning fun for the student. In the clinical areas, one method would be certain guessing contests about diagnosis, with the students having access to all information and the faculty allowed only that from the history and physical evamination or, if they prefer, as some teachers might be foolish enough to do, only that from the laboratory findings and X-rays. One might dream up various others. The important thing is that the mere attempt to achieve such an objective will result in different and probably better ideas concerning other procedures.

The relatively recent concept that our medical schools have a strong obligation not only for undergraduate and house staff education but also for continuing education of practicing physicians is an important step forward. The frequent r e f r e s h e r courses sponsored by the voluntary health agencies and presented by faculties and distinguished guests from other schools are highly desirable. The trend toward closed-circuit telecast of seminars and of conferences from our medical centers is another significant advance. But we often forget that there is only one method of day-by-day, lifelong edu-

(Continued on Page 1151)



Summer time...monilia time!

No wonder you see so many more cases of vaginal moniliasis during this season. A damp, warm bathing suit provides a perfect breeding ground for fungal invaders. But your patients need not suffer the pain, the embarrassment and the discomfort of these stubborn infections. Nor the disappointment which comes when they find "the cure didn't take."

Candeptin avoids disappointment.

With CANDEPTIN, you and your patients have good reason for confidence. *A single, 14-day course of therapy* with CANDEPTIN is usually sufficient to eradicate the invader, while rapidly relieving itching, burning, discharge and malodor. And CANDEPTIN is "cidal" as well as "static"; 100 times more potent than nystatin *in vitro,* it has achieved culture-confirmed cure rates of 90% and more (even in notoriously difficult pregnant patients). Why not maximize your chances of success by adopting effective, well-tolerated CANDEPTIN as your agent of first choice?

Agent of first choice

Candeptin®
candicidin VAGINAL TABLETS/OINTMENT

the fortnight fungicide for

PRIVATE ENEMY NO.1

Candeptin® CANDICIDIN

Formula:
CANDEPTIN Vaginal Ointment contains a dispersion of candicidin powder equivalent to 0.6 mg. per gm. or 0.06% candicidin activity in U.S.P. petrolatum. 3 mg. of candicidin is contained in 5 gm. of ointment or one applicatorful. CANDEPTIN Vaginal Tablets contain candicidin powder equivalent to 3 mg. (0.3%) candicidin activity dispersed in starch, lactose and magnesium stearate.

Indications:
Vaginal moniliasis due to Candida albicans and other Candida species.

Contraindications:
Patient sensitivity to any of the components. During pregnancy manual tablet insertion may be preferred since the use of the ointment applicator or tablet inserter may be contraindicated.

Caution:
Clinical reports of sensitization or temporary irritation with CANDEPTIN Vaginal Ointment or Vaginal Tablets have been extremely rare. To avoid re-infection, it is recommended that the patient refrain from sexual intercourse during treatment or the husband wear a condom.

Dosage:
One vaginal applicatorful of CANDEPTIN Ointment or one Vaginal Tablet is inserted high in the vagina, twice a day, in the morning and at bedtime, for 14 days. Treatment may be repeated if symptoms persist or reappear.

Dosage forms:
CANDEPTIN Vaginal Ointment is supplied in 75 gm. tubes with applicator (14-day regimen requires 2 tubes). CANDEPTIN Vaginal Tablets are packaged in boxes of 28, in foil, with inserter—enough for a full course of treatment. Store under refrigeration.

Federal law prohibits dispensing without prescription. CANDEPTIN is a registered trade-mark of Julius Schmid, Inc.

JULIUS SCHMID
PHARMACEUTICALS
New York N.Y. 10019

(Continued from Page 1149)

cation available to the practicing physician. This involves the self-education that stems from always reading about the problems he encounters in his daily practice. Our third- and fourth-year students are encouraged to do this. But such encouragement is usually half-hearted and unsupervised. One of the major objectives of our educational plan should be the development of a conditioned reflex that will tend to insure that our graduates will automatically continue, throughout their professional lives, to provide themselves with daily self-education by reading about their patients. This will involve early exposure to patients and close supervision. Admittedly, it will not be easy. But to those who say that this aim is impossible to achieve, I recommend the words of Robert Browning: ". . . a man's reach should exceed his grasp." And also those of William Shakespeare: "Our doubts are traitors, and make us lose the good we oft might win by fearing to attempt."

This brings me to a final objective which is the most controversial of all. Many of my warmest friends disagree with me. But it is only fair to state that they speak mainly from preconception, while my own views are, to a large extent, based on personal experience. In my opinion, our medical schools, especially those that are state-supported, have an obligation to render all possible aid to the public and to the profession but only insofar as such aid does not impair our primary function of high-quality education. Whether or not you agree, you will naturally ask what this has to do with the medical curriculum. My answer is that ultimately every student should have a brief period—no longer than two or three months—of exposure to the realities of medical practice in a relatively small community. In some instances, this might involve an apprenticeship with a truly outstanding family physician. Perhaps more frequently, this experience will be secured in a small community hospital. It goes with-

out saying that such an educational experience must be controlled and fully supervised by the medical school in order to be certain that students are not "used" but trained.

The presence of eager, question-asking students provides a strong stimulus to physicians to read and study. Patients, especially those who are critically ill, can receive better care when their own doctor, who is making decisions, is aided by an experienced senior student in executing those decisions. The student should have completed his initial work in all of the major clinical disciplines in the university medical school environment. He should be sufficiently mature to distinguish between mediocre practice, which he will occasionally see, and good practice, which he will usually see if the hospital has a staff of good family doctors. There should be several hours weekly of bedside teaching in depth by a full-time senior member of the medical school faculty. The program will be far better if it is "sparked" by a mature resident who is not only a rounded clinician but an enthusiastic teacher and a natural leader. Such residents are not rare. Among our youngsters there are probably ten such for every one who has the potential for the future performance of truly important research. It is likely that, with adequate remuneration, some of them would be willing to spend a year at a small hospital. The arrangement for that year to constitute accredited training toward specialty boards should present no problem if the work of the resident is properly supervised by the aforementioned senior teacher.

Again, it should be emphasized that I am strongly opposed to poor-quality education for anybody anywhere. But if it can be shown that the net effect of such broadened experience during a specified and limited time, when added to the longer period of deeper education at the home base, is as good as or even better than the latter alone, the matter assumes a different aspect. Then the only reason for opposing a plan that is beneficial to the public and to the medical profession will be faculty resistance to change. Under such a circumstance, our administrative leaders might perhaps decide to prescribe amphetamine for our faculties in order to be certain they become awake.

In summary, the following suggestions are offered as preliminary points of departure for a consideration of the objectives of the undergraduate medical curriculum:

1] To attempt strongly to create conditions favorable for the greatest possible development of feelings of dedication and obligation to patients and of compassion for them

2] To improve our teaching of bedside medicine, especially as regards the analysis of symptoms or the approach to the subjective manifestations of disease

3] To emphasize more than ever the understanding of scientific principles even at the expense of fewer memorized details that can be readily found in a book

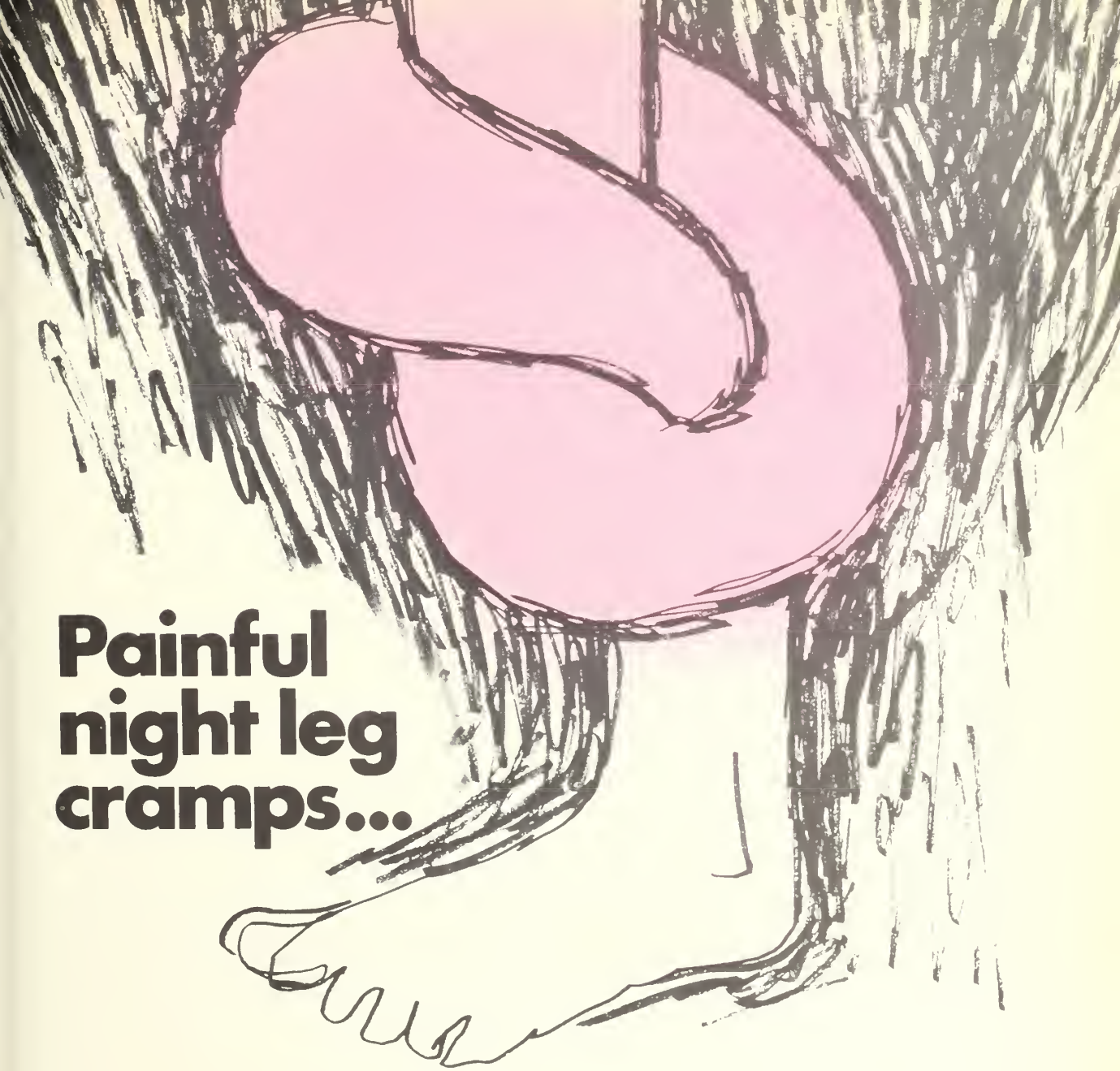
4] To make certain that our students achieve familiarity with the usual aspects of the common diseases

5] To stress the importance of the application of preventive medicine to patients of all ages

6] To attempt to make learning a pleasurable process

7] To try to develop in our students conditioned-reflex patterns that will tend to perpetuate lifelong, day-by-day continuing self-education throughout their future careers as physicians

8] To devise educational programs of high quality that will enable our students and our faculties to offer needed aid to the public and to the practicing physicians.



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

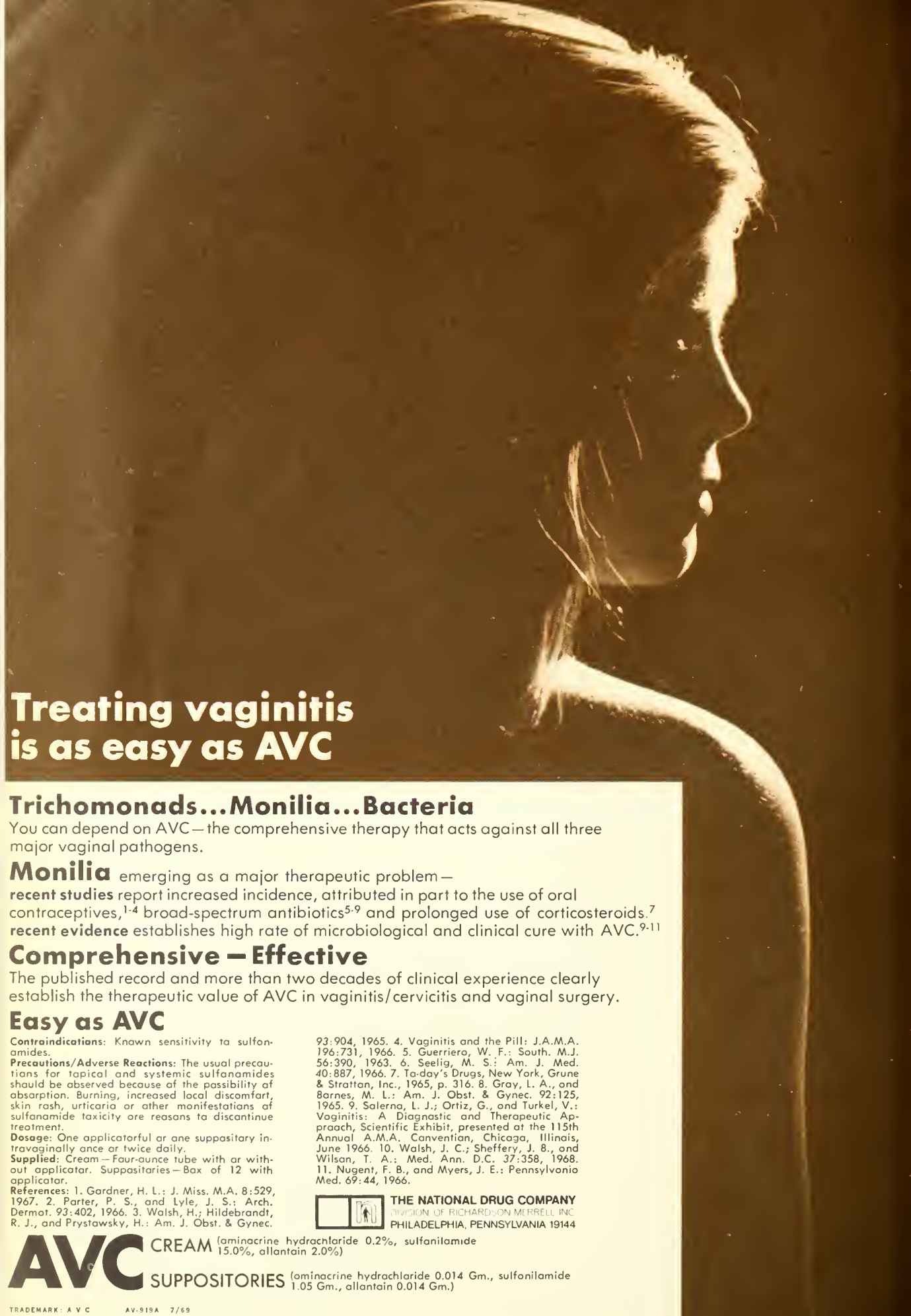
One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps



Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive—Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindicatians: Knawn sensitivity ta sulfonamides.
Precautions/Adverse Reactions: The usual precautians for tapical and systemic sulfanamides shauld be abserved because af the passibility af absarptian. Burning, increased local discamfart, skin rash, urticaria ar ather manifestatians af sulfanamide taxicity are reasans ta discantinue treatment.
Dosage: One applicatorful ar ane suppasitary intravaginally ance ar twice daily.
Supplied: Cream—Faur-ounce tube with ar without applicatar. Suppasitaries—Bax of 12 with applicatar.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Parter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystawsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. Ta-day's Drugs, New York, Grune & Strattan, Inc., 1965, p. 316. 8. Gray, L. A., and 8arnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerna, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnastic and Therapeutic Appraach, Scientific Exhibit, presented at the 115th Annual A.M.A. Canventian, Chicaga, Illinais, June 1966. 10. Walsh, J. C.; Sheffery, J. 8., and Wilsan, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

AVC CREAM (aminacrine hydrachlaride 0.2%, sulfanilamide 15.0%, allantain 2.0%)

AVC SUPPOSITORIES (aminacrine hydrachlaride 0.014 Gm., sulfonilamide 1.05 Gm., allantain 0.014 Gm.)

TRADEMARK: A V C

AV-919A 7/69



The Month in Washington

From the Washington Office
American Medical Association

Washington—The House Ways and Means Committee approved legislation that would change the medicare program to permit prepaid closed-panel group practice care and would set ceilings on physicians' fees under medicare and medicaid.

The committee did not consider national health insurance proposals for legislative action this year.

A proposal for inclusion of chiropractic under medicare was rejected. However, a compromise provision would direct the Health, Education and Welfare Department to conduct a "very limited" study of chiropractic under medicare, utilizing the experiences under medicaid. Chiropractic now is a medicaid service in 15 states, being authorized for federal funds to the extent that it is legal in the state. Representatives of chiropractors lobbied intensively with committee members for the same treatment under medicare.

The committee also decided against inclusion of social security disabled beneficiaries under medicare. Instead, the proposal was referred to the Health Insurance Benefits Advisory Council for further study.

The House was expected to approve the committee's bill, which included a five percent increase in cash social security benefits, without change. However, changes were expected in the Senate.

Provisions of the committee bill of major importance to physicians included:

—Health Maintenance Organization Option: Individuals eligible for both Part A and Part B medicare coverage would be able to choose to have their care provided by a health maintenance organization (a prepaid group health or other capitation plan). The government would pay for such coverage on a capitation basis not to exceed 95% of the cost of medicare benefits provided to beneficiaries in the area not covered under the health maintenance organization.

—Experiments and Projects in Prospective Reimbursement and Incentives for Economy: The secretary of HEW would be required to develop experiments and demonstration projects designed to test various methods of making payment to providers of services on a prospective basis under medicare, medicaid and maternal and child health. In addition, the secretary would be authorized to conduct experiments with methods of payment or reimbursement designed to increase efficiency and economy, and with community-wide utilization review mechanisms.

—Limitation on Recognition of Physician Fee Increases: Charges determined to be reasonable under the present criteria in medicare, medicaid, and maternal and child health law would be limited by providing: (a) that for fiscal year 1971 medical charge levels recognized as prevailing may not be increased beyond the 75th percentile of actual charges in a locality during calendar year 1969; (b) that for fiscal year 1972 and thereafter the prevailing charge levels recognized for a locality may be increased, on the average, only to the extent justified by increases in the cost of production of medical services, levels of living and the earnings of other professional, managerial and technical personnel; and (c) that for medical supplies, equipment and services that, in the judgment of the Secretary, generally do not vary significantly in quality from one supplier to another, charges allowed as reasonable may not exceed the lowest levels at which such sup-

plies, equipment and services are widely available in a locality.

—Payments for Services of Teaching Physicians: Medicare and medicaid would not pay for the services of teaching physicians unless other patients who have insurance or are able to pay are also charged for such services and the medicare deductibles and coinsurance amounts are regularly collected. Medicare attached payment would be authorized for services to hospital patients by staff of certain medical schools that now furnish these services without charge to the hospital.

—Termination of Payments to Providers Who Abuse the Medicare Program: The secretary of HEW would be given authority to terminate or suspend payment for services rendered by a supplier of health and medical services found to be guilty of program abuses. Program review teams would be established to furnish the secretary professional advice in carrying out this authority.

—Repeal of Medicaid Provision Requiring Expanded Programs: The requirement in present law that States have comprehensive medicaid programs by 1977 would be repealed.

—Prohibition of Reassignments: Medicare and medicaid payments to anyone other than a patient or his physician would be prohibited, unless the physician is required as a condition of his employment to turn over his fees to his employer or unless there is a contractual arrangement between the physician and the facility in which the services were provided under which the facility bills for all such services.

—Utilization Review in Medicaid: Require hospitals and skilled nursing homes participating in the medicaid and maternal and child health programs to have the same utilization review committee with the same functions as in the medicare program.

—Role of State Health Agencies in Medicaid: State health agencies would be required to perform certain functions under the medicaid and maternal and child health programs relating to the quality of the health care furnished to recipients.

—Physical Therapy Services Under Medicare: Under medicare's supplementary medical insurance program, beneficiaries would be covered for up to $100 per calendar year of physical therapy services furnished by a licensed physical therapist in his office or the patient's home under a physician's prescription. Hospitals and extended care facilities could continue to provide covered physical therapy services to patients who have exhausted their days of hospital insurance coverage.

—Chiropractors' Services: HEW would conduct a study on covering chiropractors' fees (on a very limited basis) under medicare, utilizing the experimental authority under the medicaid program. A report on

(Continued on Page 1158)

Not just a motel
it's a Guest House

. . . with 171 handsome rooms designed for your comfort and convenience. A center-of-everything location including Birmingham's University of Alabama Medical Center . . . making The Guest House a favorite of Doctor's wives and in-town outpatients. Superb dining, dancing and nightly entertainment. Come stay with us often.

THE RESTAURANT
THE PLAYROOM • CYPRESS ROOM
CONVENTION FACILITIES

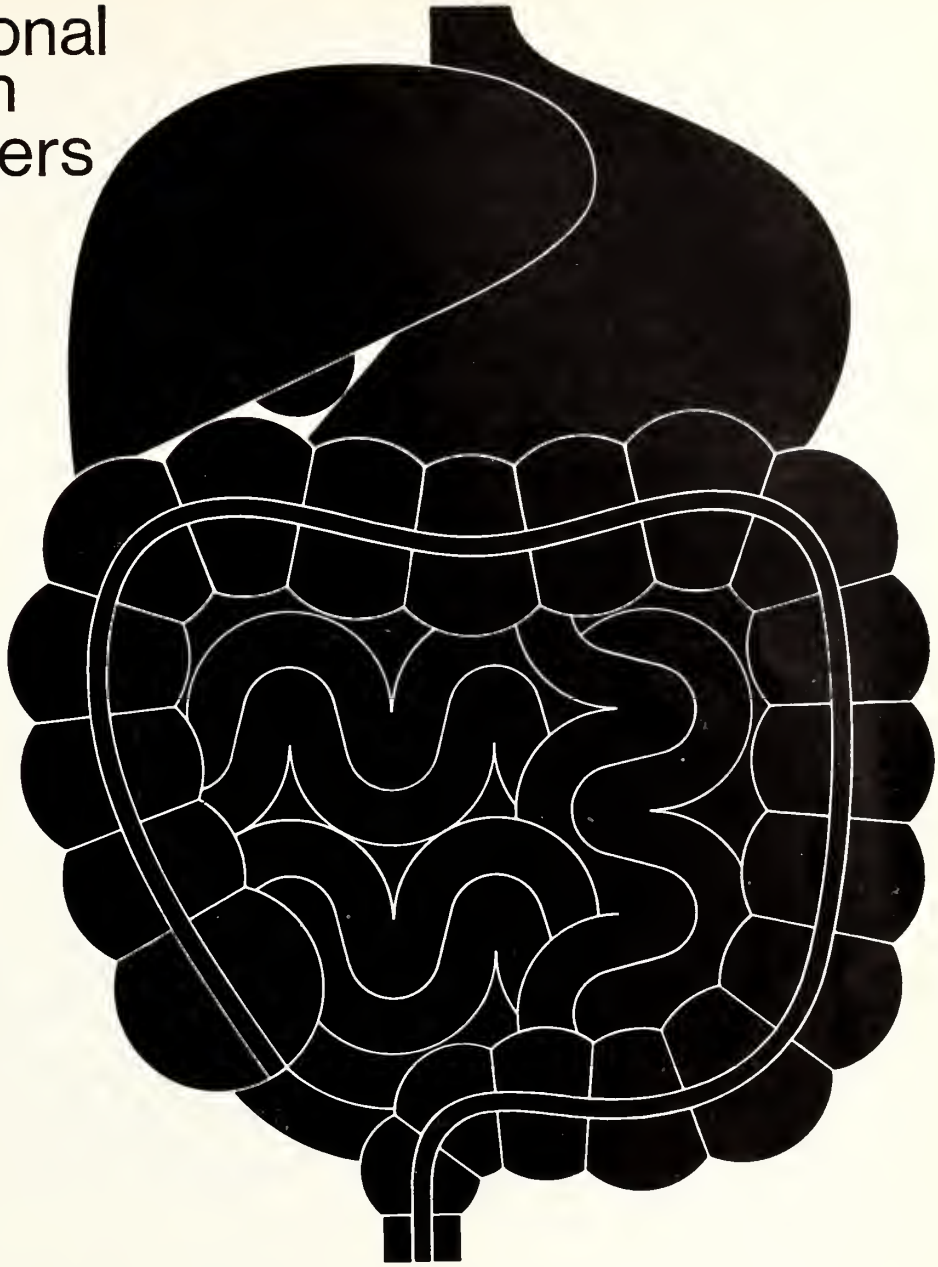


The Guest House
MOTOR INN

PHONE 324-6653
18TH ST. &
10TH AVE., SOUTH
BIRMINGHAM, ALABAMA

"Where the Action Is!"

for nutritional support in G.I.disorders



Berocca®

TABLETS
high potency B-complex and C for nutritional support

AVAILABLE ONLY ON Rx

contains water-soluble vitamins only

b.i.d. dosage provides full therapeutic amounts

good patient acceptance

no odor, and virtually no aftertaste

Each Berocca Tablet contains:

Thiamine mononitrate	15 mg
Riboflavin	15 mg
Pyridoxine HCl	5 mg
Niacinamide	100 mg
Calcium pantothenate	20 mg
Cyanocobalamin	5 mcg
Folic acid	0.5 mg
Ascorbic acid	500 mg

Usual dosage is one tablet b.i.d.

Indications: Nutritional supplementation in conditions in which water-soluble vitamins are required prophylactically or therapeutically.

Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B_{12}.

Dosage: 1 or 2 tablets daily, as indicated by clinical need.

Available: In bottles of 100.

ROCHE

Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

(Continued from Page 1156)

the study, including the experience of other programs paying for chiropractors' services would be submitted to the Congress within 2 years.

* * *

The American Medical Association expressed opposition to a proposed oral contraceptive package insert addressed to users.

The Food and Drug Administration first proposed a package insert of about 700 words dealing with possible side-effects and potential dangers of taking birth control pills. When this raised widespread opposition, the FDA drastically revised the original draft, cutting it down to about 100 words. Main objections to the first draft were that it was too long and detailed to be addressed to a patient and that it raised a serious question about the relationship between doctor and patient.

After the FDA invited comments on the revised draft from interested parties, Dr. Ernest B. Howard, executive vice president of the AMA, responded that the AMA opposes any oral contraceptive package insert. He said that, "in the best interests of the patient and the practice of quality medicine," there should be no package insert addressed to users.

". . . The requirement that information on the side-effects of a prescription drug be supplied directly to the patient is a dangerous departure from present practice," he said in a letter to the Health, Education and Welfare Department, of which FDA is a part. "It intrudes upon the patient-physician relationship and compromises individual medical evaluation. The proposed statement would lead to confusion and alarm among many patients and could result in harm to some.

"For these reasons, the American Medical Association is opposed to a package insert directed to patients for any prescription drug.

"The oral contraceptive is a prescription drug. It is the responsibility of the physician to inform his patients of the potential hazards of drugs he prescribes. In counseling on family planning, the physician has a further responsibility. He should provide information that will enable the patient to make an intelligent decision regarding the use of oral and other contraceptive methods."

"The proposed statement, in its simplistic approach to a complex situation, would confuse the patient who has already been informed of possible side-effects by her physician and who has received her physician's recommendation as to a desirable method of contraception for her. . . .

"A stated purpose of the insert is to 'reinforce the efforts of the physician to inform the patient in a balanced fashion of the risks'. The physician has a duty to weigh the benefits against the possible risk in prescribing any drug for a patient, and the physician's advice to the patient in connection with the drug prescribed must be individualized for each patient. The balanced fashion theory cannot be a part of good therapeutic practice, which requires an individual judgment for each patient. Standardized information could harm some patients by limiting the value of the specific information given to them by their physicians.

"A package insert is an inappropriate and ineffective means of providing a patient with information regarding any prescription drug. The best way to inform patients effectively is through the physician. The best way to reinforce the physician's efforts to inform the patient is to provide him with unbiased, authoritative and up-to-date information. Our Council on Drugs has used the Journal of the American Medical Association for this purpose. Further, in a forthcoming book titled AMA Drug Evaluations, we will supply the physician with comprehensive information on oral contraceptives as well as on other drugs. We would be pleased to join with the Food and Drug Administration and other concerned medical and scientific organ-

izations in the preparation of any additional information, and to provide a means of placing it in the hands of all physicians . . ."

* * *

The American Medical Association supported two Senate bills (S. 3297 and S. 3652) that would require labeling of prescription drug containers except where the prescribing physician indicated otherwise.

"We would emphasize very strongly, however," Dr. John J. Curry, a member of the AMA Council on Drugs, testified at a Senate Health Subcommittee hearing, ". . . that both bills fall short of the recommendation of the American Medical Association. In urging your support of labeling legislation, we strongly recommend that the legislative requirement provide that the label contain the established name or trade name of the drug as written by the physician, or in the case of a combination drug, the established name of the active ingredients of the drug or its trade name as written by the physician, and the quantity and strength of the drug. Provision should of course be made that the label would not contain any or all of the foregoing information where the physician so indicates."

The AMA also supported S. 3096 and another provision of S. 3297 that would require a coding identification on each tablet, capsule or other final form of a medication.

The AMA did not take a position a fourth bill (S. 3651) that would require inspection of drug manufacturing firs every six months, instead of the present two years. Dr. Curry said that he was concerned that medications he prescribed "are of maximum purity and manufactured under proper controls," but that he was not qualified to speak on the length of time between inspections.

'Twas Good Enough For Father . . .

Eighteenth Century Medicine, as noted in William Buchan's *Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines*, etc., Philadelphia, 1799:

"A flux of blood, from the anus, is not always to be treated as a disease. It is even more salutary than bleeding at the nose, and often prevents or carries off diseases. It is peculiarly beneficial in the gout, rheumatism, asthma, and hypochondriacal complaints, and often proves critical in colics, and inflammatory fevers."

"Breeding women are very subject to the tooth-ach, especially during the first three or four months of pregnancy. The tooth-ach often proceeds from scorbutic humours affecting the gums. In this case, the teeth are sometimes wasted, and fall out without any considerable degree of pain. The more immediate cause of the tooth-ach is a rotten or carious tooth."

"If the genitals be immersed for some time in cold water, it will generally stop a bleeding at the nose. I have not known this to fail."

—North Carolina Medical Journal

Wolves Don't Need To Count

"Thought Transplants," a regular feature of the magazine, *Private Practice*, offers the following:

"Man is not the creature of circumstances. Circumstances are the creatures of men."—Benjamin Disraeli.

It never troubles the wolf how many the sheep may be.—Vergil.

It isn't falling in the water that drowns a man; it's staying there too long.

We judge ourselves by what we feel capable of doing; others judge us by what we have done.—Longfellow.

HEW, AFL-CIO, Senior Citizens Join Crusade Against Chiropractic

Medicine and other branches of the scientific community have insisted for the past 75 years that chiropractic is an unscientific cult, whose practitioners are not qualified to diagnose and treat human disease.

Chiropractic, in turn, has claimed that medicine's opposition is for selfish reasons only. "The citizen has the obligation to take a firm stand against the monopolistic goals of the American Medical Association," states a booklet distributed by the American Chiropractic Association.

Until the past year, the medical profession virtually alone assumed the responsibility of informing the public about the invalidity of the chiropractic hypothesis (that human disease is caused by a spinal subluxation and cured by a spinal adjustment). Chiropractic shortcomings in education and practice were set forth.

Medicine's position is that all methods of disease prevention, health maintenance and care should be submitted to careful scrutiny and objective evaluation—the scientific process. Despite being 75 years old, chiropractic has failed to produce any scientific proof for its theories, while claiming competence to treat the broad gamut of human disease. Thus medicine opposes chiropractic for the same reason it opposes other forms of health quackery: to try to prohibit poorly-trained individuals from performing functions for which they are totally unqualified.

Significant developments from outside medicine have occurred in regard to chiropractic during the past year.

The U. S. Department of Health, Education and Welfare submitted findings of an independent, unbiased study of chiropractic ordered by Congress. In a report to Congress in January 1969 by Wilbur J. Cohen, then secretary of HEW, it was recommended that chiropractic service not be covered in the medicare program.

The report, considered to be the most penetrating analysis of chiropractic ever made, concluded: "Chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease, and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment."

HEW told Congress that its study, after evidence had been presented by chiropractic's foremost spokesmen, educators and practitioners, showed, among other things, that:

"1. There is a body of basic scientific knowledge related to health, disease, and health care. Chiropractic practitioners ignore or take exception to much of this knowledge despite the fact that they have not undertaken adequate scientific research.

"2. There is no valid evidence that subluxation, if it exists, is a significant factor in disease processes. Therefore, the broad application to health care of a diagnostic procedure such as spinal analysis and a treatment procedure such as spinal adjustment is not justified.

"3. The inadequacies of chiropractic education, coupled with a theory that deemphasizes proven causatic factors in disease processes, proven methods of treatment, and differential diagnosis, make it unlikely that a chiropractor can make an adequate diagnosis and know the appropriate treatment, and subsequently provide the indicated treatment or refer the patient. Lack of these capabilities in independent practitioners is

undesirable because: appropriate treatment could be delayed or prevented entirely; appropriate treatment might be interrupted or stopped completely; the treatment offered could be contraindicated; all treatments have some risk involved with their administration, and inappropriate treatment exposes the patient to this risk unnecessarily."

Chiropractic bitterly attacked the HEW report, and in the face of it mounted a campaign for millions of letters to Congress urging chiropractic inclusion in medicare. In an article in the December 1969 issue of the *American Chiropractic Association Journal of Chiropractic*, Cruse J. Howe, chairman of the ACA Board of Governors, outlined chiropractic's view of the urgency of creating pressure on Congress. He wrote:

"What is the stake:

"1. Chiropractic inclusion in Medicare, which leads to—

"2. Eventual inclusion in the inevitable national health program which leads to—

"3. Survival of chiropractic as a profession.

"An added bonus would be the congressional repudiation of the infamous HEW report and this in turn would remove a roadblock to state legislative projects."

Other organizations outside medicine have spoken publicly with resolutions or statements in opposition to chiropractic. Some statements have come from organizations such as the AFL-CIO and National Council of Senior Citizens, which in the past have not been on the same side of the fence as the American Medical Association in regard to federal health care matters.

Where it became a matter of providing quality health care to the elderly, as required by the medicare law, the organizations opposed chiropractic inclusion. As the National Council of Senior Citizens emphasized, "With chiropractic and other completely unscientific cults, there is no possibility for quality health care."

The AFL-CIO Executive Council recently issued a statement that said, in part:

"Of equal importance to holding down costs is the maintenance of quality care in the medicare program. Of immediate concern is the threat to quality care represented by the drive to include less than fully qualified medical practitioners such as chiropractors in the medicare program. At stake is the direct access to the billions of dollars for health care being provided the elderly by the medicare program. Medicare should not become a vehicle for exploitation of the health needs of the elderly. The AFL-CIO opposes any change in the medicare law which would open up the program to unqualified practitioners."

The National Council of Senior Citizens, an organization composed of 2½ million persons 65 years of age or older (the medicare recipients themselves), stated its views in its official newspaper, the *Senior Citizens News*, in January 1969. The article entitled "Why Chiropractic Cult Cannot Provide Quality Health Care!" included the conclusion:

"Chiropractic treatment, designed to eliminate causes that do not exist while denying the existence of the real causes, is at best worthless—and at worst mortally dangerous."

The American Public Health Association, composed of administrators of the nation's public health programs, spoke out at its annual meeting in November 1969. The APHA's governing council endorsed the HEW report and urged continued exclusion of chiropractic from medicare.

In addition, the APHA urged "that States reevaluate their existing licensure programs for chiropractors and naturopaths to determine whether such licenses should be further restricted or abolished, and that existing licensure programs be more rigorously po-

liced." The APHA resolution also recommended "that professional and consumer groups undertake appropriate consumer education on the hazards of unscientific health care, including chiropractic or naturopathy."

Continued exclusion of chiropractic under medicare was supported also by a blue ribbon task force appointed by HEW Secretary Robert H. Finch to study the problems of medicaid and related programs. Under medicaid (Title XIX of the Social Security Act) programs are state-administered with financial assistance from federal funds. Some states have authorized payment for chiropractic services under medicaid. The HEW task force reported in November 1969. It concluded that payment for chiropractic and naturopathic services "is not an effective use of federal medicaid funds."

The task force report urged, "A legislative amendment should be enacted denying federal financial participation in medicaid payments to chiropractors and naturopaths."

One of the principal drives by chiropractic in state legislatures in recent years is for passage of so-called insurance equality laws that would make inclusion of payment for chiropractic services mandatory in all health insurance policies.

The Health Insurance Council and the Health Insurance Association of America adopted a statement on "Limited Practitioners" in October 1969 that says, in part:

"The member insurance companies of the Health Insurance Council, mindful of their obligation to assure the American people that the highest possible quality of medical care is being provided, support the concept that the providers of health care should base care on scientifically-established methods of diagnosis and treatment. These companies also realize how vital it is for practitioners who hold themselves out as qualified individuals to treat human illness and disease to have adequate initial and continuing education and training. Further, such education and training, at a minimum, should be conducted in institutions that are accredited by recognized educational accrediting agencies."

A book published in September 1969, *AT YOUR OWN RISK The Case Against Chiropractic* by Ralph Lee Smith (Trident Press, New York City), presented science writer Smith's report of his extensive personal investigation of chiropractic as a patient, at a chiropractic school, at a chiropractic hospital, and as a participant in a chiropractic "practice building" course.

Smith concludes that "The theory of chiropractic is scientifically false, and treatments given in accordance with the theory bear no relationship to the cause or cure of human disease. Its practice should therefore be prohibited, and its personnel should be retrained to enter other professions."

He proposes two steps that he says must be taken by legislatures in the 48 states that license chiropractors:

> "The first step, and one that must be taken immediately, is to prohibit further use of X-ray by chiropractors . . .
>
> "The next step is for each state to create an orderly program for withdrawing chiropractic licenses."

Earlier, a federal court in Louisiana had furnished another opinion on chiropractic from outside medicine. In the case, *England Vs. Louisiana State Board of Medical Examiners*, a three-judge panel held unanimously in 1965 that the state could properly refuse to license chiropractors under the Louisiana Medical Practice Act. The U.S. Supreme Court affirmed the decision in 1966.

The court's opinion stated, "if the education obtained in chiropractic schools does not meet the standards of . . . the United States Office of Education, it may well be that the legislature of Louisiana felt that in the public interest a diploma from an approved medical school should be required of a chiropractor before he is allowed to treat all the human ailments chiropractors contend can be cured by manipulation of the spine."

Other national organizations have expressed formal concern about chiropractic. Some include:

American Cancer Society, Inc.—The ACS Executive Committee in 1967 approved an official statement saying, "Chiropractic is not based on a sound scientific medical approach to cancer and has no place in the diagnosis or treatment of cancer. Because early diagnosis and proper treatment of cancer are vital in the saving of lives and the diminution of suffering from cancer, the use of chiropractic in the diagnosis or treatment of persons afflicted with cancer represents a health hazard."

American College of Radiology—The Board of Chancellors and Council of the ACR approved a resolution in Febraury 1969 advising the public that ACR member radiologists "regard the use of radiation by chiropractors as unwarranted and without likelihood of significant medical gain . . ."

American Academy of Orthopaedic Surgeons—A resolution adopted by the AAOS pointed out that "Orthopaedic surgeons with particular knowledge of the muscloskeletal system have greater insight into the hoax of chiropractic." The resolution also requested that the Academy "establish appropriate activities to alert the professional and lay public of the hazards of such unscientific practice . . ."

National Association for Retarded Children—Upon the recommendation of its Public Health Services Committee in 1968, the NARC Board of Directors endorsed a statement saying, "Because of the increased national interest in helping the mentally retarded, it is vitally important that the NARC goes on record as stating that the Association knows of no established scientific evidence that supports the value of any current practices of chiropractors in diagnostic, therapeutic or educational activities in mental retardation."

American College of Sports Medicine—The ACSM in 1968 adopted a statement saying, "The American College of Sports Medicine does not recognize practitioners of chiropractic, naprapathy, and naturopathy as appropriate for membership in the College because the College considers the principles underlying their alleged healing practices are not founded on scientific grounds."

Support to the findings of the HEW report in excluding chiropractic services from medicare has been given by the American Hospital Association and the Association of American Medical Colleges in letters to HEW Secretary Finch.

The formal statement of policy on chiropractic adopted by the American Medical Association's House of Delegates in 1966 said, in part:

> "It is the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease. Chiropractic constitutes a hazard to rational health care in the United States because of the substandard and unscientific education of its practitioners and their rigid adherence to an irrational, unscientific approach to disease causation."
>
> Several years ago, the chiropractor serving as California director of public information of the American Chiropractic Association, in an address at a national chiropractic convention stated:
>
> "In all matters of public health, the AMA insists that it should be both judge and jury. One editorial writer called this 'papa knows best' attitude 'wholly out of place today.' After all, would a farmer hire a jackal to watch his chickens?"

This often is the chiropractic pattern—attack medicine, but offer no scientific evidence that would validate chiropractic's theories. "Medicine has the obligation to protect the public health, and it will continue to warn the public about the health hazard posed

(Continued on Next Page)

Greensboro M. D. On The Wing Of His Cherokee

A Cherokee Indian, everyone knows,
Lends his name to a beautiful, primitive rose—

To a county in our state—to a sleek Cherokee

Which is piloted by an M.D. in GP.

The thread that ties this disjointed rhyme together is to be found in the membership rosters of MASA and FPA—of the Medical Association of the State of Alabama and of the Flying Physicians Association.

Probably no other type airplane can challenge the Cherokee 180 in popularity among the Alabama doctors who fly, but only one of them was born in Cherokee County, Alabama! He is Chester Earl Singleton, M.D., and the subject of this month's entry on Alabama doctors who have earned their wings.

Centre, Ala., became the town of his nativity in one of the most interesting years in the political history of our nation. Dr. Singleton acquired his public school education there before entering the University of Alabama, from where he was graduated with his M.D. degree just fifteen years ago last month.

He interned at City Hospital, Columbus, Ga., and spent a year in general practice in Jacksonville, Ala., before entering military service. His three-year tour was spent in Germany. Thereafter he entered general practice in Greensboro, where he has been since.



Chester E. Singleton, M. D.

Dr. Singleton had been one of the five doctors in Hale County less than a year when he began flying instruction, receiving his private pilot's license in March, 1964. He flew a Piper Tri-Pacer for a few months, sold it, and two years ago bought a Cherokee-180.

The immediate past president of the Hale County Medical Society and chairman of its Board of Censors, flies mostly for pleasure with Mrs. Singleton (the former Jean Lewis of Moundville) as "a rather reluctant co-pilot" but she "is improving and, at times, seems actually to enjoy it."

They have a married daughter, Sarah (Mrs. George McKenney) also of Greensboro; a son Ted, in the 9th grade; and a daughter Abby, in the 5th grade.

Dr. Singleton may attend the 16th annual meeting of the Flying Physicians Association in Vancouver, British Columbia, Aug. 23-28 —one of a number of Alabama members planning to make it.

—W. J. M., Jr.

CRUSADE AGAINST CHIROPRACTIC

(Continued from Page 1163)

by the cult of chiropractic," states Joseph A. Sabatier, Jr., M.D., chairman of the AMA Committee on Quackery.

"In this era of scientific advancement, there must not be a double standard of health care —one scientific and one cultist. Chiropractic, if it is to be a member of the nation's health-care team, must face up to its paramount obligation—to prove, if possible, that there is scientific validity to the chiropractic hypothesis that human disease is caused by a spinal subluxation (misalignment) and cured by a spinal adjustment."

The Mentally Ill -- From Plato To Bedlam To Now

History of Mental Illness

History is filled with accounts and evidence of man's inhumanity to man, but there are few pages recording more atrocious behavior than his treatment of the mentally ill.

Man's earliest writings contained accounts of mental disorders and its treatment by incantations. Primitive man deduced that deviates were inhabited by one of the many spirits believed to be controlling existence. They tried to release the evil spirit by drilling holes into the deviate's skull, or purging him with the vilest of nostrums. When this didn't work—if the "patient" was still alive—their medicine men engaged in weird exorcistic rites, consisting of praying, cursing and beating. As a last resort they were chained, bled and starved.

It wasn't until a wise old man of medicine in the third century B.C., Hippocrates, asserted that mental disorders have natural causes and should be treated as such, that things became a little brighter for the mentally ill. But that was only temporary. Hippocrates based his work upon the theory of the four humors: "When an unbalance of these chemical substances in the body occurred, illness resulted. Conditions of frenzy resulted from an excess of bile, while too much phlegm caused depression." He also saw a connection between heredity and mental illness, head injury and brain pathology.

Plato also came to the defense of the mentally ill with the plea that they were not responsible for their acts, and should not be treated like criminals. He urged, instead, that they be given humane care in the community. Aristotle, in the following century, agreed with Hippocrates' theory of organic causes. The remarkable insight of these three men led to humane treatment of the disturbed in pleasant surroundings, and provided the first evidence of occupational and social rehabilitation. The Greeks also used dieting, massage and hypnosis. But the cruder methods of bleeding, purging and mechanical restraints were often employed for more violent patients. Some of the old attitudes and superstitions have persisted for more than 25 centuries.

The first asylums for the insane appeared in Europe in the late 16th century. Typical of these was Bethlehem Hospital in London, which came to be known as "Bedlam", a name still used today to connote disorder and upheaval. In Bedlam, violent patients were exhibited to the public for an admission fee, and it was a common occurrence for young London dandies to take their girl friends walking there on Sunday afternoons. Fruit vendors sold their products outside and these same young men would, after eating an apple, toss the core (sometime rather forcibly) at the patient. Stripped of all human dignity, the patients were subjected to beatings, chains and other means of physical force. The more fortunate were given antidotes of materials such as crabs' eyes, frog serum, dog lice, human perspiration, earthworms and vipers' flesh. Superstition still abounded, and their quarters were unspeakable.

In Colonial America conditions were little better, with communication virtually severed with any medically trained men. In Salem, Mass., 17 women were hanged and another put to death by pressing for deviate behavior. They called them witches and these atrocities committed in the name of religion. Most often, the insane were simply locked up, fed now and then, and otherwise ignored. Richer families concealed their disturbed members in boarded-up cellars or attics; but poor sufferers were left to wander about the countryside. Some were put in poorhouses, specially built kennels and cages, or secured with stocks and at whipping posts. Others were driven out of town—a practice that survived in America until the 20th cen-

tury—so the community would not have to care for them. But a few were housed with private families at public expense.

Benjamin Franklin even found time to campaign for the mentally sick and was instrumental in opening the doors of Pennsylvania Hospital in Philadelphia to the mentally disturbed in 1756. In 1773 the first mental hospital in America was opened at Williamsburg, Va.

Early Superstitions

In centuries past, some of the mentally ill were looked upon in awe, and supernatural powers attributed to them. There was little, if any, distinction between mental illness and mental retardation. So when a retarded child was observed to be "different" than other children he was revered in some cultures and better than standard living provided for him, while in other cultures he was abandoned to the wild beasts or otherwise put to death.

Some of the myths originating in the deep forests of Central Europe migrated to America with early settlers and were passed from generation to generation. No doubt the hanging of the witches in Massachusetts was done with sincere belief that they were protecting the population from the evil powers of the deviates who were believed to be possessed by the devil. One can still find some places in America where they believe that "possession by evil spirit" is the principal cause of mental illness; An idea temporarily dispelled by Hippocrates in Greece before Christ lived, scientifically disproved again and again, but kept alive in isolated areas for thousands of generations. In rural areas of Pennsylvania there are said to be covens of witches and hex signs are painted on barns to ward off evil. In the South we can still find people who have been "conjured".

When the first American mental hospital was established in Williamsburg in 1773, it served the whole of Tidewater and Piedmont, Virginia as well as a scattered few from southwest Virginia which then extended to the Mississippi River. Superstition and legends about witches, evil spirits, and supernatural powers moved westward with the settlers. When a horse carrying a mentally ill man from the mountains of Virginia to the hospital at Williamsburg panicked and leaped over a cliff, killing both the horse and rider, belief was kindled that the mentally ill could transmit their illness to animals. Moon madness or lunacy was a common term during those days and many dogs barking at a full moon were accused of being under the influence of a mentally ill person or persons—or the moon itself—still looked upon as influencing men's minds. People in many places throughout rural America wore charms and medallions around their necks to ward off mental as well as physical illness. This belief still persists among certain cults today.

Jum C. Nunally, Jr., of Vanderbilt University, Nashville, conducted some opinion research in 1954-60 to determine information held by the general public. This was later published as *Popular Conceptions of Mental Health.* Opinions expressed, ranged from a belief that the blood of the insane is blue, to a belief that mental illness is not a hopeless condition.

Since 1960, reams have been written and TV and radio programs have given countless hours of time to mental health education. There is little doubt that the general public now knows much more about mental illness than it did ten years ago. The stigma that has its foundation in superstition and ignorance is gradually fading. More people know that mental illness is not hopeless. But they likewise know that the American Medical Association was right when they—during the last decade—labeled mental illness, "America's Most Complex and Troublesome Health Problem".

A lack of understanding by families, and friends, often complicates treatment. This is a major reason for efforts to move treatment of the patient back into the community. When one realizes that rejection by friends and families is often followed by a stay in

jail for no crime but illness, it isn't hard to see why some people might not be motivated to return to their home community from a large isolated hospital. One patient who has been in one of Alabama's mental hospitals has been visited only four times since his arrival. He has been found to be completely truthful on all questions except, "Have you ever been in jail?" He vehemently denies it. His only jail record is while awaiting transportation to the hospital 22 years ago. At the same hospital, a patient died at 84 last year. His age upon admission, 14. During his seventy year stay he didn't have a single visitor from the outside world.

This is why those who work professionally with the mentally ill and mentally retarded are so happy to see old superstitions and myths give way to enlightenment. They can measure the response and remotivation of many patients shown by families, and friends from the local community.

First Asylums In America

Late in the 18th century, humanitarian reformers in the United States and abroad made significant progress in care of the mentally ill.

It was during this period when for the first time, the study and treatment of mental illness was raised to a scientific level. Dr. Benjamin Rush (1745-1813), who organized the first course in psychiatry in this country, used popular methods of bleeding, restraint and cold showers at Pennsylvania Hospital. But they were used without deliberate cruelty, and patients were provided decent quarters and other comforts. Dr. Rush introduced occupational therapy, amusements and exercise, still essential features of recovery in Alabama state hospitals and others throughout the world.

In Paris, during the French Revolution, Dr. Philippe (CQ) Pinel (1745-1826) had become physician-in-chief of an asylum where patients had been chained to the walls of dark cells. His removal of the chains, some from patients restrained for more than 30 years, was an unprecedented step, taken in the face of protests and warnings. Dr. Pinel also dispensed with bleeding and other violent treatment methods, focusing instead on patients' minds. He dramatized a belief that mental patients deserve the same consideration extended other suffering humanity.

In 1796, when William Tuke founded York Retreat, a Quaker institution in England, harsh treatment was forbidden except for occasional use of a straitjacket or solitary confinement. A religious atmosphere prevailed, and patients were treated like guests in a family environment.

Some of the most significant contributions to mental health care were made by J. E. D. Esquirol, a pupil of Pinel. He was the first to apply statistical methods to his clinical studies, and as early as 1805, regarded emotions as a source of mental illness. Esquirol differentiated certain depressive states from the other psychoses, a forerunner of the modern concept of depressions. He introduced the term, "hallucinations," giving it today's precise definition, limited to hearing or seeing things which are not there.

By 1850, there were 20 asylums in the United States. A survey of that year revealed that since 1818 only 24,329 patients had been treated therein. While some of the ideas of Pinel and Tuke had been adopted, the facilities and services available were too meager to meet the needs.

The aged, orphaned and poor were often jailed or grouped together as paupers and treated like animals. Some were hidden away in attics, cellars and outhouses. Others were packed into almshouses, run out of town or sold into slavery.

"Psychiatry" was still an unfamiliar word at mid-century; "medical psychology" being a term more in use. However, in 1844, the Association of Medical Superintendents of American Institutions for the Insane had organized, later to be known as the American Psychiatric Association. Evolving techniques from clinical observation and trial and error, its members created a new profession. They

recognized the value of moral treatment, but felt that in the first stages of mental illness, medication was more important.

The history of the Medical Association of the State of Alabama and the beginning of a hospital system are closely intertwined, linked with the name of Dr. Albert Mabry of Selma. Under his leadership, the new association fought political opposition until in 1852, the governor signed an act for the establishment of the Alabama Insane Hospital, later named for its first superintendent, Peter Bryce.

The association's efforts had been supported by several visits to the state by a noted reformer, Dorothea Dix, who crusaded at the international level for more humane treatment of the insane. It was not until 1860 that the first superintendent was appointed.

By the turn of the century, programs of care for the mentally ill with centralized administrative authority had become more numerous throughout the country. Some had initiated a progressive plan permitting patients to live together in home-like cottages, rather than the impersonal atmosphere of a large, imposing building.

Today, the realization that mental patients benefit from treatment as individuals still helps to bring about their cure. And while the continued use of large institutions may be projected well into the future, hopes are that modern preventive methods will steadily decrease the numbers of their residents.

The Dorothea Dix Movement

"I do not come to present a view of fancied ills, to rattle the chain, nor to utter the shriek of the maniac in your ear." These words were spoken to the Alabama Legislature in 1849 by a great crusader for humane treatment of the mentally ill.

Deeply stirred eight years earlier by the sight of mentally ill who were thrown in a Massachusetts prison with criminals of both sexes, Dorothea Dix had embarked on a campaign for improved facilities and treatment that brought success in this country and abroad.

Her campaign alerted the press, aroused public opinion and resulted in the establishment of large mental hospitals in at least 15 states and Canada. Although today's progressive thinking is moving away from big institutions, and in the direction of small regional hospitals and community mental health centers, Miss Dix helped make more humane treatment of the mentally ill available for generations to come.

A bill she presented to Congress called for 12,255,000 acres of federally owned land for the indigent insane. After passing both houses, it was vetoed by President Franklin Pierce. Miss Dix then turned to Scotland, England and Europe, bringing about revolutionary changes in their systems. Some sources credit the total number of mental hospitals she was responsible for founding or enlarging as 32.

She traveled in every state east of the Rockies, gathering information about the insane. After seeking social and political influence, she addressed the Alabama Legislature asking for the building of an asylum.

In Alabama Miss Dix disclaimed an approach on an emotional basis. Probably aware of the legislature's opposition to proposals made previously by the Medical Association, she attempted an appeal to reason.

"For the dreaded malady, we know that in these latter days there is for most of its victims a remedy, and for all, alleviation. But neither healing nor palliative influences can be had without appropriate means involving public action and government support," she said.

"Much has been done, but much remains to be accomplished for the relief of these sufferers in our United States as in other countries. With a population rating at more than 22,000,000 our insane and idiots number at the lowest estimate, 22,000. And not 5,000 at this time have the advantages of appropriate care in well organized hospitals, or

comfortable situations adopted to their condition and circumstances elsewhere," according to her address at that time. She reported the existence of 20 state hospitals in 19 states of the Union.

"I have seen hundreds of patients restored to their health and returned to the enjoyments and blessings of domestic life; and I have seen thousands living in misery, wearing life slowly out in dungeons, cells, cages, pens, barns and outhouses, exposed to every variation of weather, filthy and neglected, abandoned of friends, cared for with less consideration than the oxen in the stall, or the swine in the sty; melancholy monuments of the imperfections with which society discharges its social and moral obligations," she told the Alabama Legislature.

Failure of the bill to pass was probably due partly to the burning of the State Capitol. It was not until the winter of 1852 that establishment of the Alabama Insane Hospital was fully approved.

During the Civil War, Miss Dix served as superintendent of women nurses for government hospitals, returning to her work with the mentally ill afterwards. She died at 85 in a Trenton, N. J., hospital established through her efforts.

Her humanitarian work will long be remembered in the annals of mental health. Yet, many of the institutions she so zealously fought to establish eventually became over-crowded and under-staffed. Others who followed, concerned about the plight of the mentally ill, again deplored the conditions under which mental patients lived.

Their hope for the future is that with modern, enlightened treatment of emotional conflicts, the number of people caught in a web of mental illness will be greatly reduced and the number hospitalized will be much smaller. The brightest outlook is that, in time, the big isolated institutions will become a thing of the past and most patients will be treated in their own communities.

Mental Retardation

The challenge of helping meet the needs of the state's mentally retarded looms large among the problems confronting the Alabama Department of Mental Health. After years of public apathy and misunderstanding, however, positive changes are in view.

Few are aware of the magnitude of the problem, but a conservative estimate is that there are 100,000 mentally retarded persons in the state, most of whom are mildly retarded and live with their families. Efforts are now being directed towards making available to them the help that is needed, so that most can continue to remain at home or as near there as possible.

The late Gov. Lurleen B. Wallace is largely responsible for a brighter outlook for the retarded and their families. It was through her influence that funds were appropriated for the building of four developmental centers. The first, named in her honor, is under construction at Decatur. Construction is beginning on a second center at Mobile. The others will be built at Birmingham and Wetumpka.

Altogether, 1,600 additional beds will then be available, all of which could be filled immediately. A majority of parents, however, neither wish nor seek institutional placement, except as a last resort, after much hardship has been endured. Mental health professionals support them in their stand.

According to a state plan for serving as many families as possible, the new centers will concentrate services on persons in need of short-term or periodic residential services, including some profoundly retarded and and non-ambulatory patients. Partlow will continue to serve the entire state for most of the profoundly retarded, and for those for whom long-term residential care is needed.

The new centers will each serve a specified area, and a section of Partlow will also be designated as a regional center for that sec-

tion of the state. The overall goal is to develop an array of services in the community, to encompass a continuum of services for all ages and ability levels.

The regional center's staff will consult and assist local communities to develop an array of programs and services such as day training centers, sheltered workshops and half-way houses for the retarded. Study groups for parents, teachers, ministers, physicians, rehabilitation counselors, public health nurses and others who deal with the retarded and their families will be part of the on-going program.

Mental Hygiene Movement

The National Association for Mental Health which has some 1,000 chapters throughout the United States is a vibrant organization that has come of age during the past 15 years. Early in the 20th century, Clifford W. Beers, having spent several years in various mental institutions during which time he scratched with broken glass on his ward wall, "God Bless our home which is hell," wrote an historic book, *A Mind That Found Itself,* in which he revealed the harsh treatment and lack of therapy for the patients. Conditions described from his own experience were no better than those that had aroused Dorothea Dix a half century before.

Beers made it his life's work to develop a program of mental hygiene for the nation and the world. In 1909 he succeeded in forming the National Committee for Mental Hygiene which adopted as its purpose:

(1) Establishment of reforms in the care and treatment of mental patients.

(2) Education of the public to create a more humane and intelligent attitude toward the mentally ill.

(3) Research into the causes, nature and treatment of mental disorders.

(4) Creation of services for the prevention of mental breakdown.

In 1946 the National Mental Health Act was passed which led to the establishment of the National Institute of Mental Health. Soon thereafter the National Committee for Mental Hygiene became the National Association for Mental Health and responsibility for objectives 3 and 4 were, more or less, left to N.I.M.H.

The joint efforts of the National Association for Mental Health and the National Committee Against Mental Illness, headed by Mr. Mike Gorman, an Oklahoma newswriter and author, led to the establishment in 1955 of a Joint Congressional Commission on Mental Illness and Health. Gorman, who had been appointed by President Truman in 1951 as Director and Chief Writer of the President's Commission on the Health Needs of the Nation, was appointed to the Joint Commission.

The Commission's Report, *Action for Mental Health,* published in 1961, shocked the nation into a new awareness of the need to improve mental health services. President John F. Kennedy's deep concern was voiced in his message to Congress in February 1963 calling for a "bold new approach" to the problems of mental illness-retardation. A perspective of the problem showed it to be too large to be tackled by state and community governments alone, and later that year The Community Mental Health Centers Act Public Law 88-164 came into being. Ironically, just weeks after President Kennedy signed the Act into law, he was assassinated by a man for whom mental treatment had been urged. But recommendations for Oswald's treatment had gone unheeded, or else services were simply unavailable.

The goal of community services is to create in strategic locations, covering population areas no greater than 200,000 nor less than 70,000 people, a full range of preventive and treatment services.

The minimum of five to be included are:

(1) Inpatient (treatment in local general hospitals).

(2) Outpatient (treatment in clinics or hospitals with patient returning home).

(3) Partial Hospitalization (patient remains at hospital during day or during night, with remainder of time spent at home or on the job.)

(4) 24 Hour Emergency Service (crisis intervention—suicide prevention, etc.).

(5) Education and consultation service for individuals and community agencies. Purpose is to help frontline caregivers who are already doing what is essentially mental health work every day . . . teachers, ministers, public health nurses, policemen and medical practitioners.

Alabama has four comprehensive centers actually under construction with several more in advanced stages of planning. In addition to these centers for the mentally disturbed, four more Developmental Centers for the retarded are under construction or in advanced stages of planning. They are to be located in Decatur, Birmingham, Mobile and Wetumpka.

Autopsy In Maternal Demise

The Maternal Mortality Study Committee in its review of death frequently finds itself in a dilemma in deciding the precise mode and manner of death. Evaluations of methods of treatment obviously lose their value when the reliability of the original diagnosis remains in doubt.

As an illustration, one may use one of the more common types of cases which are encountered—the patient who collapses shortly after an apparently uneventful delivery, and dies relatively quickly. The clinical diagnoses usually present several choices, either massive amniotic fluid embolism, pulmonary embolism, or concealed hemorrhage secondary to rupture of the uterus. Without an autopsy, it is frequently impossible to accurately catalog the cause of death. Since the methods of treatment of the different pathologic entities are quite different, obviously it becomes quite important to determine which method of death occurred.

Modern medical science is largely based on observations made at the autopsy table. At the present time, medical research is most concerned with sophisticated instrumentation which measures biochemical and physiological changes in the living cell. As a result, the autopsy is no longer emphasized as a research tool in the large medical centers, and tends to be neglected. However, the problems of every day practice are still best resolved by actual observation of the pathologic changes which have contributed to the patient's death. The Maternal Mortality Study Committee would, therefore, urge all physicians to strive to obtain as high an autopsy rate as possible. Autopsy protocols on every death would greatly help the Committee and the attending physician. The results of the Committee can be seen in the progressive reduction of possibly preventable deaths during childbearing from 39 in 1953 to 15 in 1967.

—By Edward A. Birge, M. D.
in Wisconsin Medical Journal

INDEX TO ADVERTISERS

Arch Laboratories 1136

Breon Laboratories 1099
Blue Cross-Blue Shield 1131
The Bradley Center ..... 3rd Cover
Burroughs Wellcome 1144

Campbell Soup 1121
Classified 1128
Dow Chemical Company 1133

Flint Laboratories 1104, 1105

Guest House Motel 1156

Highland Hospital 1127
Hoechst Pharmaceuticals 1091
Hynson, Westcott & Dunning, Inc. 1075

Lederle Laboratories 1077, 1172
Eli Lilly & Company ..... 1st Cover, 1107

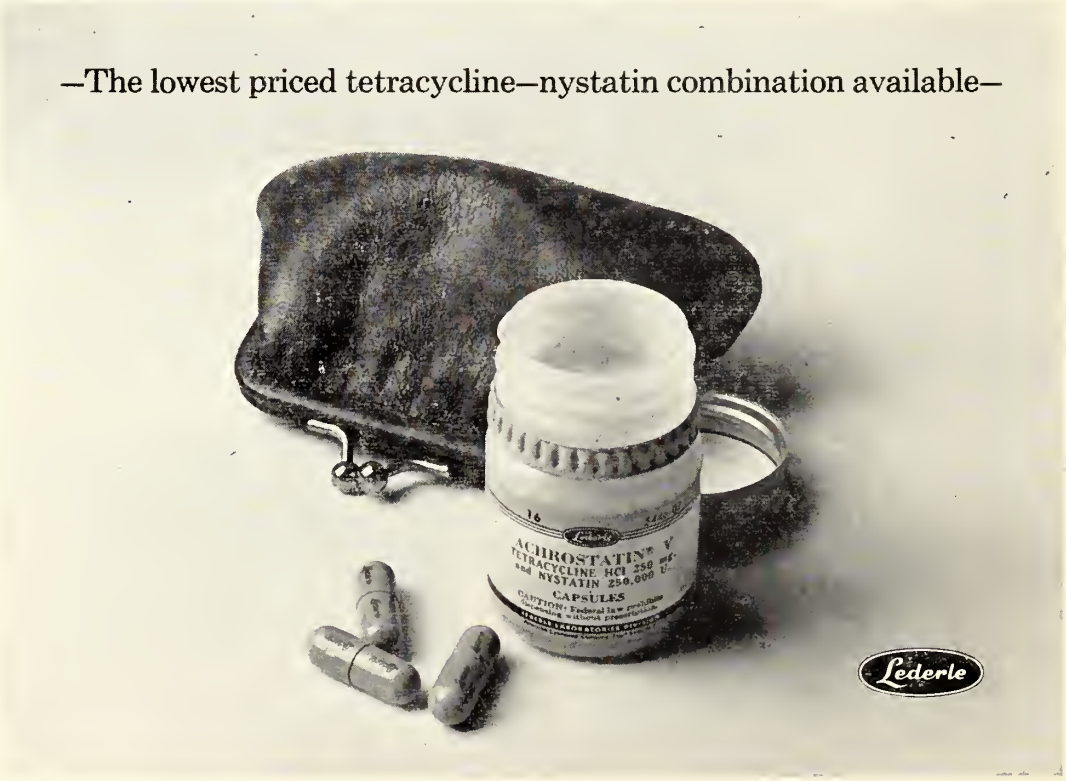
National Drug Company ..... 2nd Cover, 1153, 1154

Chas. Pfizer Company 1092, 1093, 1094
Wm. P. Poythress & Co., Inc. 1134, 1143

A. H. Robins Company 1124
Roche Laboratories ..... 1097, 1157, 4th Cover

Julius Schmid 1150, 1151
Schering Laboratories 1085, 1086, 1087, 1088
G. D. Searle 1122, 1123

—The lowest priced tetracycline—nystatin combination available—



INDEX

THE JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

Volume 39

July 1969—June 1970

Explanatory Notes

Arrangement of Index

I. Authors

II. Titles

III. Association Forum

IV. Alabama Department of Public Health

I. AUTHORS

B.

Blount, Walter P., M. D.—Early Recognition and Prompt Evaluation of Spinal Deformity, 749

Bolding, O. Thomas, M. D.; Wilcutt, Herman C., Ph. D.—Physiological and Psychological Evaluation of the Estrogen Deprived Patient, 459

Brascho, Donn J., M. D.; Durant, John R., M. D.; Moody, Frank G., M. D.; Roth, Robert E., M. D.; and Maddox, William A., M. D.—A Proposal for the Management of Hodgkin's Disease at the University of Alabama Medical Center, 1107

C.

Carmichael, Erskine, M. D.—Laparoscopy in Gynecology 241

G.

Grimley, K. W.—Volunteers and Tuberculosis, 1021

H.

Hudson, Henry C., M. D.; Seofield, George F., M. D.; Hundley, Rube, M. D.; Gates, William, Jr., M. D.—Renal Angiomyolipomas: Report of Two Cases and Review, 141

L.

Laws, Henry L., M. D.—Peripheral Vascular Injuries, 913

M.

Marshall, Wallace, M. D.—Normal and Abnormal Behavior from Learning, 40

Marshall, Wallace, M. D.—Immunologic Augmentations for Learning and Psychiatry, 243

Marshall, Wallace, M. D.—Immunologic Psychology and Psychiatry, 649

Moody, Frank G., M. D.—The Latest Concepts in Surgical Management of Peptic Ulcer Disease, 464

N.

Nachman, Mrs. Louise—A Patient Speaks, 1016

R.

Rackley, Charles E., M. D.—Specialized Hospital Care of Coronary Artery Disease, 551

Reque, Paul G., M. D.; Lauderdale, Robert O., M. D.—"The Use of Locorten (Flumethasone Pivalate) Cream in the Treatment of Common Dermatoses," 919

S.

Schwartz, Ferdinand F., A. B., B. S., M. D., F. I. C. A., A. A. P. M. R., M. R. S. H.—If Life Is Prolonged, Make it Enjoyable, 361

Shedd, Charles L., Ph. D.—The Concept of "Readiness" and Learning Disabilities, 29

Spira, Henry, M. D., F. A. P. A.—The Meal Ticket Syndrome, 37

T.

Till, Harry J., M. D.; Cameron, John M., M. D.; Dorrough, Robert L., M. D.—Fylephlebitis and Liver Abscesses Following Appendicitis, 831

Turner, A. Jack, Ph. D.; Michels, T. J., Ph. D.—The Psychologist as the Psychiatrist's Pathologist, 150

Tysinger, D. S., Jr., M. D.—The Place of Respirators in the Coronary Care Unit, 355

Tysinger, D. S., Jr., M. D.—Pulmonary Function Testing for the General Hospital and Physician (Part I), 555

Tysinger, D. S., Jr., M. D.—Pulmonary Function Testing for the General Hospital and Physician (Part II), 658

Tysinger, D. S., Jr., M. D.—Pulmonary Function Testing for the General Hospital and Physician (Part III), 756

Tysinger, D. S., Jr., M. D.—Pulmonary Function Testing for the General Hospital and Physician (Part IV), 834

Tysinger, D. S., Jr., M. D.—Pulmonary Function Testing for the General Hospital and Physician (Part V), 922

Tysinger, D. S., Jr., M. D.—Pulmonary Function Testing for the General Hospital and Physician (Part VI), 1113

W.

Wool, Verna, Ph. D.—The Psychology of the Tubereulous Patient, 1011

II. TITLES

A.

A Patient Speaks (Nachman), 1016

C.

Concept of "Readiness" and Learning Disabilities, The (Shedd), 29

E.

Early Recognition and Prompt Evaluation of Spinal Deformity (Blount), 749

I.

Immunologic Psychology and Psychiatry (Marshall), 649

Immunologic Augmentations for Learning and Psychiatry (Marshall), 243

L.

Laparoscopy In Gynecology (Carmichael), 241

Latest Concepts in Surgical Management of Peptic Ulcer Disease, The (Moody), 464

Life is Prolonged, Make it Enjoyable, If (Schwartz), 361

M.

Meal Ticket Syndrome, The (Spira), 37

N.

Normal and Abnormal Behavior from Learning (Marshall), 40

P.

Peripheral Vascular Injuries (Laws), 913

Physiological and Psychological Evaluation of the Estrogen Deprived Patient, (Bolding, Wilcutt), 459

Place of Respirators in the Coronary Care Unit, The (Tysinger), 355

Proposal for the Management of Hodgkin's Disease at the University of Alabama Medical Center (Brascho, Durant, Moody, Roth, Maddox), 1107

Psychologist as the Psychiatrist's Pathologist—A Rebuttal (Turner, Michels), 150

Pulmonary Function Testing for the General Hospital and Physician (Part I) (Tysinger), 555

Pulmonary Function Testing for the General Hospital and Physician (Part II) (Tysinger), 658

Pulmonary Function Testing for the General Hospital and Physician, (Part III), (Tysinger), 756

Pulmonary Function Testing for the General Hospital and Physician, (Part IV), (Tysinger), 834

Pulmonary Function Testing for the General Hospital and Physician, (Part V), (Tysinger), 922

Pulmonary Function Testing for the General Hospital and Physician, (Part VI), (Tysinger), 1113

Psychology of the Tubereulous Patient, The (Wood), 1011

Pylephlebitis and Liver Abscesses Following Appendicitis, (Till, Cameron, Dorrough), 831

R.

Renal Angiomyolipomas: Report of Two Cases and Review, (Hudson, Scofield, Hundley, Gates), 141

S.

Specialized Hospital Care of Coronary Artery Disease (Rackley), 551

U.

"Use of Locorten (Flumethasone Pivalate) Cream in the Treatment of Common Dermatoses, The" (Reque, Lauderdale), 919

V.

Volunteers and Tuberculosis (Grimley), 1021

III. ASSOCIATION FORUM

Development of Areawide Comprehensive Health Planning Agencies In Alabama, 704

Drs. Wilbur and Rogers Differ on Future of Medicine, 157

Health Problems in Colonial Alabama, 1051

Medicaid Payment for Individual Practitioners—A Definition, 255

Peer Review and Medicaid, 1125

Peer Review Polishes Mirror for Improved Doctor's Image, 819

Percentile Payment Formulas as Used in Medicare and Medicaid, 260

Review of Legislative Developments Relating to Health and Medicine, 367

Rising Medical Care Costs—What to Do?, 791

SSA Regulations for Coverage of Injections, 567

Tubal Ligation and Abortion in the State of Alabama, 945

Use of Prisoners for Drug Trials in Alabama, The, 396

IV. ALABAMA DEPARTMENT OF PUBLIC HEALTH

A Survey to Assess Public Participation in a Rubella Immunization Program in an Alabama County, 537

Darkfield Microscopy Quickly Diagnoses Syphilis, 795

Health Education Curriculum Development Workshop, 345

Huge TVA Nuclear Poser Plant Checked for Pollution, 876

Intensified Tuberculosis Program in Tuscaloosa County, 637

Manpower Shortage No. 1 Health-Planning Challenge, 51

Mobile County—A Child Centered Program to Prevent Tuberculosis, 183

Pesticide Program Begun, 508

Registered Nurse Utilization—A Key to Improved Patient Care, 973

BUREAU OF PREVENTABLE DISEASES

Frederick S. Wolf, M. D., Director

Current Morbidity Statistics

1970

	April	May	*E. E. May
Tuberculosis	102	96	130
Syphilis	32	23	129
Gonorrhea	698	749	345
Chancroid	0	0	2
Typhoid fever	1	1	0
Salmonella	17	30	11
Undulant fever	0	0	0
Shigella	8	7	5
Amebic dysentery	0	1	3
Scarlet fever & strep. throat	435	363	200
Diphtheria	0	0	0
Whooping cough	3	2	3
Meningitis	14	5	6
Tularemia	0	0	0
Tetanus	1	2	1
Poliomyelitis	0	0	0
Encephalitis	1	1	8
Smallpox	0	0	0
Measles	1	38	292
German measles	49	64	11
Chickenpox	175	156	79
Mumps	43	34	68
Infectious hepatitis	44	53	39
Typhus fever	0	0	0
Rocky Mt. spotted fever	0	1	0
Malaria	0	4	0
Cancer	439	721	728
Rheumatic fever	7	6	13
Rheumatic heart	19	21	18
Influenza	103	15	90
Pneumonia	417	334	297
Rabies—Human cases	0	0	0
Pos. animal heads	4	8	9

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

The more corrupt the state, the more laws. —Tacitus.

"Don't believe the world owes you a living; it doesn't owe you a thing—it was here first."—Robert Burdette.



The Bradley Center --- for the problems of living

An all new homelike open psychiatric residence on a lovely five-acre tract, centrally located within the community, providing a comprehensive range of continuous services, including in-patient, day care, and outpatient treatment. Each patient participates in an extensive and intensive treatment program, based almost exclusively upon multiple psychotherapeutic encounters. These include individual psychotherapy, group psychotherapy, the nursing milieu, occupational therapy, recreational therapy, topical small group discussions, and other group activities in the Center, as well as in the community, depending on individual needs and interests. Medications are prescribed when appropriate.

Any individual may be admitted who, in the opinion of the medical staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible family member.

Accredited by the Joint Commission on Accreditation of Hospitals.

Leonard T. Maholick, M. D.
Medical Director

Maj. Gen. (ret.) Howard Snyder
Administrator

THE BRADLEY CENTER, INC.
2000 Sixteenth Avenue
Columbus, Georgia 31901
Area Code 404 324-4882



When disease is ruled out and psychic tension is implicated

Valium® (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110